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ABSTRACT

State programs designed to influence the geographic and specialty distribution of health professionals are examined. Summaries of 113 state health professions distribution programs operating in 1985-1986 are grouped by state and include information on the type of incentive, goals, eligibility, clinical specialties, funding, and physician characteristics. Attention is also given to: methods used by states to recruit physicians for shortage and underserved areas; the range of programs adopted by states, program goals and strategies; state level of effort and changes since 1981, and results that are relevant for state and federal policy. Detailed attention is given to the methods for determining specific areas of need and to the extent to which these methods rely on or are different from the approach used in designating federal health manpower shortage areas. Strategies employed by state health distribution programs concern: selective recruitment to undergraduate medical schools; influencing experiences during schooling; financial incentives to locate in certain areas; and aid in establishing and maintaining practices. (SW)

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Compendium of State Health Professions Distribution Programs: 1986

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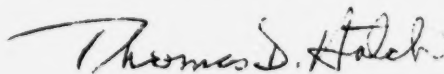
PREFACE

One of the major objectives of the programs of the Bureau of Health Professions (BHPr) is to help improve the geographic distribution of health personnel. Similarly, many States have developed programs to influence their own geographic distribution. Most of these State programs offer incentives to health personnel to encourage them to practice in particular locations after completion of training, and many of them identify specific areas in their State with a relative shortage of health professionals as preferred practice locations. Since the objectives of such State programs are similar to those of Federal programs, it is important for the BHPr to have current information on the content and extent of State programs aimed at redistributing physician manpower and on the methods by which States identify areas in need of additional health personnel.

This report describes the over 100 State health professions distribution programs known to be in place in 1985-1986, the methods used by States to recruit physicians to serve in shortage/underserved areas, and the methods States use to identify shortage/underserved areas. It updates and expands the information contained in a 1981 University of Michigan report, National Compendium of Non-Federal Physician Distribution Programs, which examined then-current State programs aimed at redistributing physician manpower into geographic areas of greatest need.

The present report also describes changes over the last five years in these programs, including those that have been initiated, expanded, reduced or terminated. Differences among the various types of State programs are discussed, and information is provided on how State initiatives in health professions distribution programs have changed as a result of the national increase in overall physician supply and other factors. The methods States use for determining their specific areas of need are examined in detail to determine the extent to which they rely on or are different from the Federal health manpower shortage area (HMSA) criteria.

This compendium and report was prepared by Lewin and Associates, Inc. for the Bureau of Health Professions, under Health Resources and Services Administration contract No. 240-85-0062. Ann Zuvekas served as Project Manager, under the direction of Jack Needleman, and was assisted by Judith Arnold and Katherine Eresian. Eugenia Carpenter, author of the University of Michigan's 1981 Compendium, was a consultant to Lewin and Associates on this project. Betty Hambleton of BHPr's Office of Data Analysis and Management (ODAM) served as the Project Officer, in consultation with Richard C. Lee, Chief of ODA's Distribution and Shortage Analysis Branch, and Howard V. Stambler, Director of ODA.



Thomas D. Hatch

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COMPENDIUM OF STATE
HEALTH PROFESSIONS DISTRIBUTION PROGRAMS:
1986

Table of Contents

	<u>Page</u>
EXECUTIVE SUMMARY:	v
CHAPTER ONE: INTRODUCTION	1
A. <u>Background</u>	1
B. <u>The Scope and Focus of this Report</u>	2
C. <u>How this Information Was Compiled</u>	3
CHAPTER TWO: AN OVERVIEW OF STATE HEALTH PROFESSIONS DISIRIBUTION PROGRAMS	6
A. <u>What Is the Range of Programs States Have</u> <u>Adopted? What Are the Goals of these Programs</u> <u>and the Strategies behind Them?</u> <u>What Have Been their Outcomes?</u>	6
1. Selective Recruitment to Undergraduate Medical Schools	7
2. Affecting Experiences during the Educational Process	12
a. Increasing the resources available to primary care	12
b. Supporting public medical schools	13
c. Purchasing seats in health professions schools	14
d. Sponsoring changes in curriculum	14
3. Financial Incentives to Locate in Certain Areas	17
4. Aid in Establishing and Maintaining Practices	22

	<u>Page</u>
B. <u>What Is the State Level of Effort in Health Professions Distribution Programs and How Has this Changed since 1981?</u>	23
1. Current Level of Effort	23
2. Trends in Level of Effort since 1981	31
C. What Can Policymakers Learn from the State Initiatives?	33
 CHAPTER THREE: STATE SERVICE AND SHORTAGE AREA CRITERIA	 38
A. <u>Descriptions of State Criteria</u>	38
1. Health Manpower Shortage Areas (HMSAs)	39
2. HMSA Modifications	40
3. Population-to-Physician Ratios	40
4. Community Size	40
5. Anywhere in the State	41
6. Different Criteria	41
a. California	41
b. Illinois	42
c. New York	43
d. Oregon	43
e. Comparison with HMSA	43
7. Other	45
B. <u>Conclusion</u>	45

	<u>Page</u>
CHAPTER FOUR: PROGRAM DESCRIPTIONS	47
A. <u>Glossary</u>	47
1. Administrative Locus	47
2. Administrator	47
3. Type of Incentive	47
4. Narrative Description	48
5. Goals	48
6. Participating Institutions	48
7. Eligibility	48
8. Area Selection Criteria	48
9. Conditions	48
10. Service Obligation.....	49
11. Buyout Provisions	49
12. Standards for Program Evaluation	49
13. Outcome	49
14. Annual Funding Levels	49
15. Current Source of Funding	49
16. Participant Profile	49

	Page
B. <u>Program Descriptions</u>	50
1. Alabama	51
2. Alaska	54
3. Arizona	59
4. Arkansas	64
5. California	73
6. Colorado	78
7. Florida	79
8. Georgia	84
9. Idaho	93
10. Illinois	96
11. Indiana	103
12. Iowa	104
13. Kansas	107
14. Kentucky	122
15. Louisiana	131
16. Maine	132
17. Maryland	143
18. Massachusetts	152
19. Michigan	163
20. Minnesota	174
21. Mississippi	179
22. Missouri	182
23. Montana	185
24. Nebraska	188
25. Nevada	191
26. New Hampshire	194
27. New Jersey	197
28. New Mexico	200
29. New York	213
30. North Carolina	228
31. North Dakota	235
32. Ohio	238
33. Oklahoma	243
34. Oregon	256
35. Pennsylvania	261
36. Rhode Island	272
37. South Carolina	275
38. South Dakota	282
39. Tennessee	283
40. Texas	288
41. Utah	297
42. Virginia	300
43. Washington	308
44. West Virginia	315
45. Wisconsin	320
46. Wyoming	323

COMPENDIUM OF
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS:
1986

EXECUTIVE SUMMARY

I. SCOPE OF THE COMPENDIUM

Sparked by concerns for access to health care and the problems that can occur when insufficient numbers of physicians and other health professionals are available, federal and state governments have developed a variety of programs to influence the geographic and specialty distribution of health care professionals. These programs attempt to increase the number of primary care providers, as well as to increase the number of health personnel working in underserved areas.

This Compendium, sponsored by the Bureau of Health Professions (BHP), provides information to federal and state policymakers on those state efforts. It examines current state initiatives and changes in those initiatives over the past five years. It offers examples of innovative state approaches which can be used by both the federal and state governments in examining health professions distribution efforts. The Compendium also discusses the various state approaches to identifying areas of greatest need for health professionals.

II. AN OVERVIEW OF STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

A. Program Approaches, Goals, and Outcomes

The federal government and most states have designed programs to address two problems -- the lack of primary care providers and the scarcity of providers in some geographic areas, usually remote rural communities and depressed inner cities. To these two problems, some states add concern that the total number of health professionals in the state is inadequate.

Taking into account the personal and professional factors affecting specialty and location choices, programs have sought to intervene at key points in the health professional career decision process. The programs may be grouped according to four strategies: 1) selective recruitment to undergraduate medical schools; 2) affecting experiences during the health professions educational process; 3) financial incentives to locate in certain areas; and 4) aid in establishing and maintaining practices.

1. Selective Recruitment to Undergraduate Medical Schools

All public and some private medical schools give preferential treatment to in-state applicants or to applicants most likely to select rural practice. By preferentially selecting students predisposed to practice in rural areas, medical schools may increase their chances of graduating physicians who will choose rural practice. Programs which give preferential treatment to admitting students from rural or underserved areas also incorporate other strategies, such as exposure to underserved areas or financial aid, into the program. The success of the selective recruitment component of programs is

difficult to assess because it is integrated with other incentives. States also promote opportunities for individuals from disadvantaged backgrounds to pursue medical education. Two programs account for 80 percent of the total identified minority participants.

2. Affecting Experiences during the Educational Process

State programs have also attempted to influence specialty and location choices during the educational process. While these are not the most common approaches, these efforts show the greatest variations in methods. They have increased the resources available to primary care (and thus perhaps its professional standing), supported public medical schools, and sponsored changes in curriculum which increase students' exposure to both primary care and underserved areas.

a. Increasing the resources available to primary care

Many states have provided subsidies to family practice residency programs, initially to stimulate the development of additional training programs and more recently to maintain enrollment levels.

Eleven states have developed programs with a distributional focus in addition to providing subsidies for family practice residency programs. By targeting residencies in underserved areas, program officials believe there is a greater likelihood that graduates will choose to practice in underserved areas. Generally, programs supporting primary care residencies report that the majority of graduates practice in the state.

b. Supporting public medical schools

Thirty-nine states have public medical schools. Since 1970 seven new public medical schools have become operational. Most were designed to afford educational opportunities for areas of the state with few such opportunities, as well as to produce more primary care physicians for rural areas. Many of the targeted distributional programs discussed by the Compendium are sponsored by public institutions.

c. Purchasing seats in health professions schools

Eight states without their own public medical schools purchase seats in out-of-state health professions schools to enable state residents to attend those schools. Three of these programs require a commitment to return to the state to practice for a period of time. Seat purchase programs with a service commitment appear to have a greater proportion of students who return to practice in the state than seat purchase programs without a service commitment.

d. Sponsoring changes in curriculum

Curriculum changes are intended to provide alternatives to the traditional hospital-focused medical education experience in order to influence provider preferences through exposure to certain specialties or geographic areas. Of the 18 programs identified in 10 states, most are designed to place undergraduate medical students into preceptorships with community

physicians, usually in rural areas. Few preceptorships provided a quantitative measure of program success or failure. Program administrators reported that students are enthusiastic about their preceptorship experience, and one university, in which all students are required to serve a preceptorship, reports well over half their graduates are seeking primary care residencies.

While preceptorship programs account for the majority of curriculum changes, states have pursued other innovations, mainly enrichment programs to increase the number of health professionals from minority or rural backgrounds. Area Health Education Centers (AHECs) are another large-scale effort to support training outside of major academic medical centers.* The 12 AHECs in the Compendium, now largely supported by states, provide decentralized training and continuing education and support to practicing physicians. Their activities vary widely and are tailored to individual state needs and local initiatives. Improvements in accessibility and quality of care as well as in retention of physicians in underserved communities have been attributed to participation of community physicians in such AHEC training and other activities.

3. Financial Incentives to Locate in Certain Areas

The most common state approaches to distributional problems are financial incentives to health professionals to locate in certain areas. Of the 113 state programs identified in the Compendium, financial incentives account for 39 programs in 26 states. Thirty-five programs require that recipients serve in shortage areas. Service-contingent programs vary in the amount and form of financial aid available, the service requirements, and the buyout provisions. Those 15 programs with strict buyout provisions, such as high interest rates and penalties, tend to have the greatest number of physicians and dentists fulfilling their obligation.

Selectively recruiting individuals with a preference for rural practice is another way to increase the number of students who fulfill their obligations. Still other states have tried having communities participate in funding aid and then having the supported student work in the community during training.

Service-contingent programs appear to be an effective way to place health professionals in underserved areas. High penalties for buyout and selective recruitment of individuals with a preference for rural practice contribute to the success to these programs.

4. Aid in Establishing and Maintaining Practices

The programs described thus far largely direct their efforts at recruiting, training, or supporting students during the educational process. Other programs direct their efforts at recruiting and retaining health professionals after they have completed their medical education, using different approaches to aid in establishing and maintaining practice.

* AHECs serve dual roles; in addition to decentralized training, many AHECs provide continuing medical education and offer assistance to practicing providers.

Some programs establish a computerized list of places to be matched with health professionals, but do not attempt to assist the physicians in establishing practices. Other programs aid health professionals in locating, establishing, and maintaining practices through financial and/or technical assistance often coordinated by creating a primary care infrastructure.

The effectiveness of programs that assist health professionals in establishing and maintaining practice in underserved areas appears to depend on the level of ongoing support provided. Programs that provide financial assistance in setting up a practice as well as technical and management assistance in maintaining that practice are better able to retain providers in underserved areas than programs more limited in scope such as computerized placement lists.

B. STATE LEVEL OF EFFORT IN HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

States vary greatly in the number of programs they have, the available funding, and the number of program participants. Nine states have no programs whose major goal is the distribution of health professionals. Eleven states report four or more programs, usually with hundreds of participants. While some of the state-to-state variation in programs can be explained by need for physicians, in many states other factors are also involved in decisions to establish or end these programs.

State appropriations represent the primary, but not the only, source of funding for programs identified in this study. On average, state funds represent 76 percent of total budgets, federal funds 11 percent, local funds 6 percent, and private funds 7 percent. The proportion of state funding varies across program types, with service-contingent and seat purchase programs having the highest proportion of state funds.

All sources of financial support for non-federal health professions distribution programs have increased substantially between 1980 and 1985. Thirty-eight programs have been discontinued since 1981. No patterns seem to exist regarding the geographic distribution or type of discontinued program. Since 1981 eleven new programs have been established. Four programs replaced discontinued programs; the others were added to existing state programs. These included AHECs, loan program for practicing physicians, service-contingent loan programs, and a post-training loan forgiveness program.

Program-by-program changes in the number of participants from 1980 to 1985 are mixed. Of the 31 programs reporting program participants in both years, 16 experienced a decrease in participants while 12 experienced an increase. Service-contingent programs account for the majority of programs which decreased in number of participants.

C. LESSONS FROM THE STATE EXPERIENCE

The outcomes of health professions programs are mixed, since there are so many factors affecting provider specialty and location choice. Nonetheless, several lessons can be learned from examining state initiatives in health professions distribution.

1. Integrated multiple strategies have a better chance of success in attracting and retaining health professionals in shortage areas than does a single strategy.

Most of the programs identified in the Compendium have tended to focus on a single strategy, but a multi-faceted approach is being implemented in a number of states. These approaches combine several strategies, including active recruitment, preceptorships and other educational experiences, assistance to communities trying to recruit physicians, and financial assistance for education, practice start-up and practice in economically depressed areas. Integration can be difficult to implement, but it appears to be most successful where there is a program manager or outside political figure pushing for and encouraging greater cooperation among programs.

2. Service-contingent programs are an effective but expensive method to place health professionals; preceptorships and other curriculum changes are significantly less expensive but may not be as effective.

While service-contingent programs appear to be more effective on a person-by-person basis, more people can be involved in other programs for each dollar spent. It is not clear from the available information which type of program is most efficient in encouraging placement of physicians in shortage areas, nor the precise impact of types of programs operating together. Rigorous evaluation of the relative cost and impact of these approaches appears to be an essential component of any determination whether program goals are being met.

3. Service-contingent programs with high penalties for buyout are an effective means of temporarily recruiting health professionals to shortage areas.

States have generally found that high buyout penalties induce more students to serve in shortage areas. Retaining former obligees in shortage areas once their commitment has expired has become an important independent program goal.

Some states, recognizing that the increased supply of physicians has eased earlier recruitment problems, have shifted emphasis to efforts to develop the health services infrastructure in underserved areas. In the words of one administrator, "The pool [of physicians] is sufficient, but there is a need for site development." Many state policymakers and program managers recognize that some areas in their states lack the economic base to support financially viable physicians' practices. They are searching for the most cost-effective methods to retain physicians in such areas.

III. STATE SERVICE AND SHORTAGE AREA CRITERIA

Of the 113 Compendium programs, 61 (54 percent) have some type of shortage area criteria. About a third use the federal HMSA criteria or slight modifications of them. With the exception of eight programs in four states, the remaining programs place personnel in areas according to population-to-physician ratios, rural community size, placement anywhere in the state or on

a case-by-case basis. These generally more lenient provisions enable programs to place many more health professionals throughout the state than the use of HMSA alone would have allowed.

The HMSA criteria are important to the administration of state programs. With the exception of the eight programs in four states which employ alternative criteria, states are not duplicating or substituting for the HMSA process. The widespread use of the HMSA methodology indicates that program administrators believe HMSA designations are adequate for placing health professionals in communities in need. Changes do not appear to be needed in the definition of a rational service area or the physician-to-population ratios.

However, some states place a different priority on elements in the HMSA criteria. For example, New York and Oregon use criteria that place a higher priority on health status measures than health resource availability in measuring areas of underservice. These state officials believe that health status measures provide a more accurate indicator of lack of access to care than physician-to-population ratios.

IV. PROGRAM DESCRIPTION

The full report includes descriptions of each program and a summary table of the range of programs in each state. It describes the program design and administration and, to the extent information was available, the number of participants and funding levels.

CHAPTER ONE

INTRODUCTION

This Compendium, sponsored by the Bureau of Health Professions (BHPr), provides information on state efforts to influence health professions distribution. It examines current state initiatives and changes in those initiatives over the past five years. It also offers examples of innovative state approaches which can be used by both the federal and state governments in examining health professions distribution efforts.

The Compendium also discusses the various state approaches to identifying areas of greatest need for health professionals. Federal managers continually monitor the Health Manpower Shortage Area (HMSA) designation process and its related placement policies so as to make improvements as necessary to assure that limited federal resources are targeted to areas with the greatest need. Both state and federal governments are particularly interested in improving approaches to examining the availability and accessibility of health professionals to populations in otherwise adequately served areas and better federal-state cooperation in collecting data for this purpose.

A. BACKGROUND

Sparked by concerns about access to health care and the problems that can occur when insufficient numbers of physicians and other health professionals are available, federal and state governments have developed a variety of programs to influence the geographic and specialty distribution of health care professionals. These programs attempt to increase the number of primary care providers, as well as to increase the number of health personnel working in underserved areas. Programs have been implemented at the medical school, residency, and practice levels. They use a variety of mechanisms -- targeting selection of students, changing training to increase exposure to primary care and underserved areas, providing financial support through loans and grants, and assistance in setting up and maintaining practices.

Many of these programs were established at a time when it was felt that there was an overall shortage of physicians, when the proportion of physicians entering primary care was declining, and when many rural and inner city areas experienced great difficulty in recruiting health care personnel. During the 1970s, federal policy was directed toward increasing the total number of health professionals as a strategy for ameliorating the problems of maldistribution. Some officials argued that increasing the supply of physicians would benefit underserved communities as greater numbers of physicians spilled over into remote rural and inner city communities. Efforts included subsidies to build medical schools, per student direct payments (called seat purchase or capitation) to enlarge the classes of existing medical schools, and numerous scholarship and low interest loan programs to enable more students to attend medical school.

Some of these conditions are now easing, in part due to these federal and state initiatives. The proportion of physicians entering primary care has increased. While many areas remain underserved, it now appears to be easier to recruit physicians to some shortage areas. By the 1980s, after seeing

evidence of a large increase in physician supply, concern has increased about a potential surplus of physicians. This concern was fueled by the report of the Graduate Medical Education National Advisory Committee (GMENAC) in 1981, which concluded that shortages of primary care physicians would be eliminated during the 1980s, and that a surplus of physicians would exist in most fields by 1990.

Despite the increasing supply of physicians, many geographic areas still appear to lack sufficient health professionals to assure adequate access to care. While frequently cited studies done at Rand, for example, have found that as the supply of specialists increased smaller communities became able to attract physicians, other studies suggest that underserved areas with poor prospects for economic growth were unlikely to attract physicians despite increases in the total state supply, and that the more a state's physician increase consists of highly specialized doctors, the less the state can expect to see diffusion into underserved areas.

In response to the increasing supply of physicians and to the rise of support for a more limited role for the federal government in most areas of public policy, federal health manpower policy has also changed. Support for health professions education has decreased, as has the number of physicians being recruited through the National Health Service Corps (NHSC) scholarship program, although efforts are underway to recruit volunteer NHSC members. The direction of state policy is unclear, as states balance the effects of increasing numbers of health professionals on the one hand with declining federal support to health professions programs on the other. This report summarizes the states' efforts to affect distribution of health professionals in their areas.

B. THE SCOPE AND FOCUS OF THIS REPORT

This report describes the current state programs directed at influencing health professionals' geographic and specialty distribution. Updating the 1981 University of Michigan School of Public Health report National Compendium of Non-federal Physician Distribution Programs, the report examines the current range of state programs and how they have changed over time and also provides substantial detail on the structure, financing, methods, and experience of these programs. It is useful to federal officials who need to know about the scope of state programs, and to state officials who want to examine their own programs in light of the efforts and experience of other states.

The report is organized into three additional chapters:

¹ Schwartz, W.B.; Newhouse, J.P.; Bennett, B.W.; and Williams, A.P. "The Changing Geographic Distribution of Board Certified Physicians." The New England Journal of Medicine 303 (October 30, 1980): 1032-8.

Fruen, M.A. and Cantwell, J.R. "Geographic Distribution of Physicians: Past Trends and Future Influences." Inquiry 19 (Spring 1982): 44-50.

Chapter 2. An Overview of State Health Professions Distribution Programs. The second chapter presents an analysis of the experience of state programs, organized around three questions:

- What is the range of programs states have adopted? What are the goals of these programs and the strategies behind them? What have been their outcomes?
- What is the state level of effort in health professions distribution programs and how has this changed since 1981?
- What can federal and state policymakers learn from the state initiatives?

Chapter 3. State Service and Shortage Area Criteria. The federal government has invested substantial effort in developing shortage area criteria for directing health resources and personnel to areas with substantial needs. Many states use either the federal criteria or minor modifications to the federal approaches in their programs with service requirements. Others use extremely broad definitions of eligible areas, including in some cases the whole state. Four states have developed approaches to designating shortage areas that differ significantly from the federal approaches while delineating specific areas. Because of the federal and state interest in designation methods, this chapter describes the criteria in use and the major alternative approaches adopted by states.

Chapter 4. Program Descriptions. The fourth chapter consists of detailed state-by-state, program-by-program descriptions of the activities identified in the Compendium.

C. HOW THIS INFORMATION WAS COMPILED

To gather information on state programs, an attempt was made to contact administrators from each of the 144 programs listed in the 1981 Compendium. In addition to program administrators, DHHS regional office representatives were contacted as well as the state NHSC coordinators and others to ensure no programs had been missed. While some of the original individuals were still managing the same programs, there was a great deal of turnover in many programs. After determining the status of the programs in the 1981 Compendium and contacting the appropriate individuals, other programs were identified that either were not found in the earlier Compendium or were established after 1981.

While this Compendium expanded on the 1981 effort, it is not intended to be a comprehensive catalog of all state activities that affect health professions distribution. Some states, such as Minnesota and Ohio, for example, are attempting to retain health professionals in the state by assuring the survival of rural hospitals. One approach taken by Minnesota is

to relax restrictions on the number of swing beds that can be certified for Medicare reimbursement. Such efforts are not presented here. The 113 programs in 42 states that were selected for the Compendium met the following criteria:

- The program had a stated purpose to improve health professions distribution. For example, a residency program incorporating rural preceptorships would be included whereas a residency program without such special distributional efforts would be excluded.
- The program attempted to affect specialty and location choice by altering individual health professionals' choices. A service-contingent program requiring service in an underserved area would be included, while a program to build hospitals in rural areas would be excluded because it lacks a direct influence on career choices.

The Compendium excludes the states' general support for health professions education such as funding of public universities and subsidies of private education, including only those programs that are designed to have distributional effects.

Based on written material about the programs and follow-up telephone calls to program administrators, program descriptions were prepared. These draft descriptions were then sent to state program administrators for review to confirm or correct information.

Information from the state programs was entered into a database to facilitate analysis. This system allowed the information to be sorted by numerous variables and to analyze trends across variables from 1981 to 1986.

The 1986 Compendium has made several improvements to the methodology used in 1981. The 1981 Compendium was largely a mailed survey, while the 1986 Compendium was based on a review of published material on state programs and telephone calls to confirm or clarify this information. Telephoning increased the number of responses for which information was compiled, as well as the completeness of the information. As a result, the 1986 information is more complete and perhaps more reliable.

The updated Compendium expanded the practitioner focus to include dentists and other health professionals from the earlier Compendium's focus on allopathic and osteopathic physicians only. While physicians were the primary focus of this study, administrators also were asked whether their distribution programs included dentists and other health professionals. Given the difference in approach, trend analysis from 1981 to 1986 for non-physician health professionals would be misleading, since the greater number of dentists and other health professionals in the 1986 Compendium is directly related to the methodology.

This 1986 report has more complete information on funding levels, participant levels, and program outcomes. Many programs in the earlier Compendium had not existed long enough to report program outcomes. By 1986, these programs had one or two years of program outcomes to report, although

these data elements are still incomplete in 1986 either because they are not collected by the programs or because they were not made available to us.

CHAPTER TWO

AN OVERVIEW OF STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

Federal and state governments have sponsored a variety of approaches designed to increase the proportion of primary care providers and the numbers of health professionals practicing in underserved areas. This Compendium offers the opportunity to describe the state programs as they exist in 1986 and to study their outcomes for guidance for future policies related to health professions distribution programs.

Information from both the 1981 Compendium and this 1986 update was used to answer the following questions:

- What is the range of programs states have adopted? What are the goals of these programs and the strategies behind them? What have been their outcomes?
- What is the state level of effort in health professions programs and how has this changed since 1981?
- What can federal and state policymakers learn from state initiatives?

This chapter is organized around answers to those questions.

A. WHAT IS THE RANGE OF PROGRAMS STATES HAVE ADOPTED? WHAT ARE THE GOALS OF THESE PROGRAMS AND THE STRATEGIES BEHIND THEM? WHAT HAVE BEEN THEIR OUTCOMES?

The federal government and most states have designed programs to address two problems: 1) the lack of primary care providers and, 2) the scarcity of providers in some geographic areas, usually remote rural communities and depressed inner cities. To these two problems, some states add concern that the total number of health professionals in the state is inadequate, no matter how much they specialize or where within the state they locate. State governments have addressed these distributional problems, but their approaches have varied according to their perceptions of the nature of the problem and its root causes, the resources available, political ideologies, and other factors.

The dual choices of health professionals' specialty and location appear to be intertwined.² Lack of the economic and population bases required to support specialists demands that many rural and inner city areas will attract primary care providers and not specialists, if they attract any providers at all. For example, a pediatric cardiologist is unlikely to practice in a community of 10,000 population, while a general pediatrician might choose to locate there. Programs may be designed to influence specialty choice for

² For an excellent synthesis of the available literature see Richard Ernst and Donald Yett, Physician Location and Specialty Choice (Ann Arbor: Health Administration Press, 1985).

its own sake, specialty choice as a method of affecting location choice, or location choice directly.

Program officials believe that health professionals choose what and where they will practice based on both personal and professional factors. While the causal relationships have not been precisely specified, important personal factors are: preference for rural or urban lifestyle, proximity to family and friends, and the availability of social, cultural, and educational opportunities. The professional factors likely to influence location include access to hospital privileges, the desire for adequate income, and a need to avoid professional isolation. State programs have addressed all of these factors.

Taking into account the personal and professional factors affecting specialty and location choices, programs have sought to intervene at key points in the health professional career decision process. The programs may be grouped according to four strategies:

- Selective recruitment to undergraduate medical schools.
- Affecting experiences during the health professions educational process.
- Financial incentives to locate in certain areas.
- Aid in establishing and maintaining practices.

Each of these strategies will be discussed in turn. Exhibit 1 displays the programs types by their point of intervention in the professional decision process. Table 1 displays the distribution of the programs by state, as well as the new and discontinued programs since 1981.

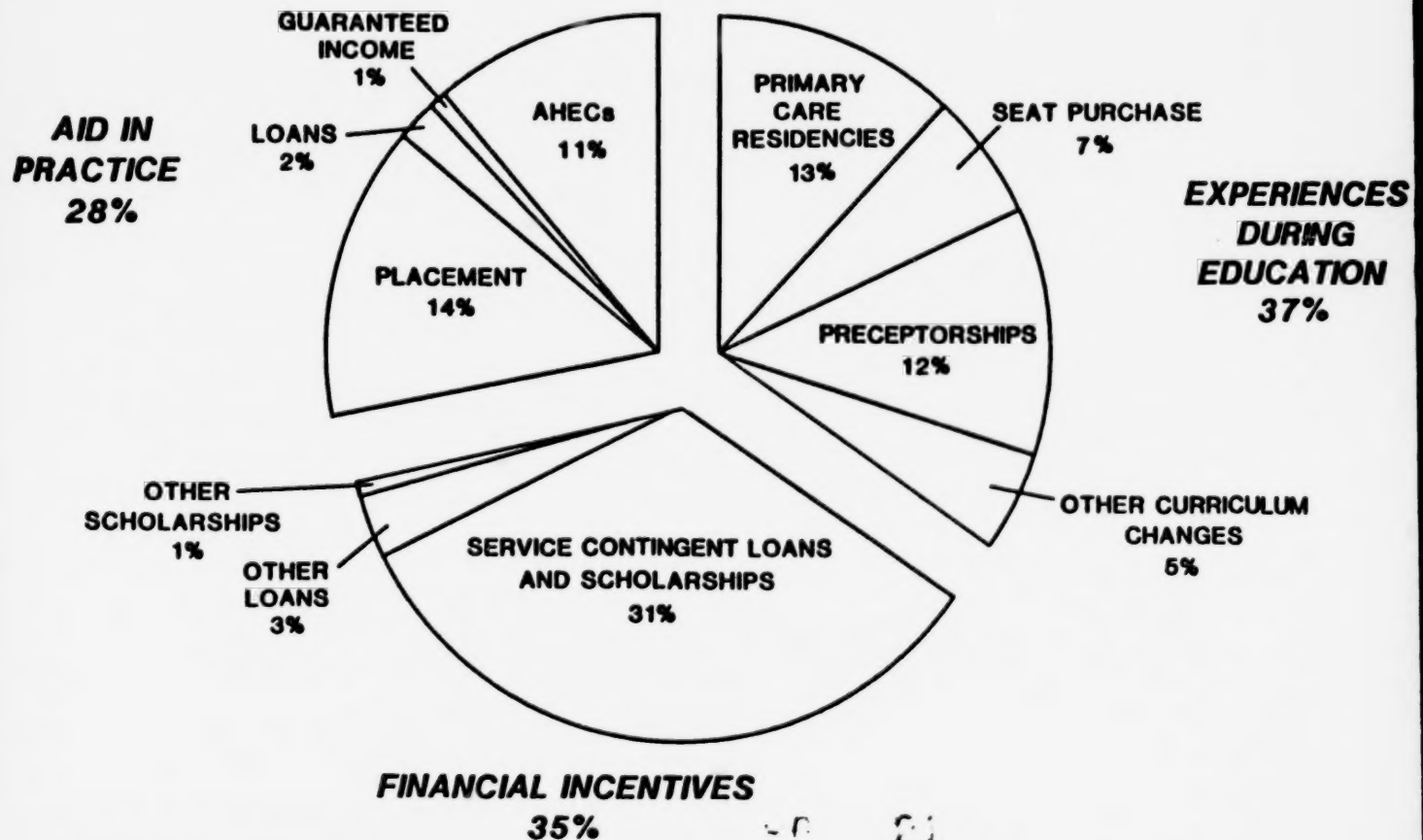
1. Selective Recruitment to Undergraduate Medical Schools

All public and some private medical schools give preferential treatment to in-state applicants or to applicants most likely to select rural practice. In choosing students most likely to serve in underserved areas, schools have relied on preadmission interviews and application screening questionnaires. For example, the Kentucky Professional Education Preparation Program provides grants to educational institutions to operate enrichment programs to increase the number of rural residents who attend medical school. In Pennsylvania the Gannon program operates curriculum innovations to attract rural residents to medical school. These two programs accounted for 35 percent of the total identifiable rural participants in the compendium. By preferentially selecting students predisposed to practice in rural areas, medical schools may increase their chances of graduating physicians who will choose rural practice.

Programs which gave preferential treatment to admitting students from rural or underserved areas also incorporated other strategies, such as

EXHIBIT I

FOCUS OF 112* STATE PROGRAMS IN THE COMPENDIUM



* NOT INCLUDING ONE PROGRAM, AN ADVISORY BODY, WHICH DOES NOT FIT INTO THE CATEGORIES SHOWN HERE

Table 1
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

	EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
	TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
REGION I											
Connecticut											
Massachusetts	X	X			X			X			X
Maine	-	X		-	X		X				X
New Hampshire			X								
Rhode Island		X			-						
Vermont											
REGION II											
New Jersey	X				-						
New York	X	X	X	X	X						
REGION III											
Delaware											
District of Columbia											
Maryland					X	X					
Pennsylvania			X	X		X	-				
Virginia					X			X			X
West Virginia					X						X
REGION IV											
Alabama					X						
Florida	X							X			
Georgia	X				X			X			
Kentucky	X			X	X						X
Mississippi					X						
North Carolina					X			X			X
South Carolina					X			X			X
Tennessee			X								*

Table 1 (continued)
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

	EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
	TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AMECs
REGION V											
Illinois	X				X						
Indiana	-				-						
Michigan	X		X		-			X			
Minnesota		-	X								
Ohio			X	-	X						
Wisconsin	-				-			X			
REGION VI											
Arkansas					X			X		X	X
Louisiana			-					-			
New Mexico			X	X	X			X		+	
Oklahoma	X				X			X			X
Texas	X				X	X		-			
REGION VII											
Iowa	X										
Kansas	X	-	X		X			X			X
Missouri					X						
Nebraska	-				X						
REGION VIII											
Colorado								-			
Montana		X									
North Dakota					-			X			
South Dakota					-						
Utah								X			
Wyoming					X						

Table 1 (continued)
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

	EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
	TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AMECs
REGION IX											
Arizona					X						
California	X			-	-					X	
Hawaii											
Nevada								-	X		
REGION X											
Alaska		X			X						
Idaho		X									
Oregon	X							X			
Washington	X	X			X			-			

X = Presence of program.
+ = Program added since 1981.
- = Program discontinued since 1981.

exposure to underserved areas or financial aid, into the program.³ The success of the selective recruitment component of programs was difficult to assess because it is integrated with other incentives. For example, in a service-contingent program directed toward rural residents, it is difficult to determine whether a successful outcome is the result of selective recruitment or of the requirements for service in designated geographic areas. Among the three programs with a selective recruitment component, only one provided outcome information. The Gannon Program in Pennsylvania reported that two-thirds of program participants entered primary care and many located in rural areas.

States also promote opportunities for individuals from disadvantaged backgrounds to pursue medical education, somewhat like the federal Disadvantaged Assistance and Exceptional Financial Need Scholarship Programs. Since research⁴ has found that low-income and minority individuals are more likely to choose primary care specialties and to practice in shortage areas, a secondary objective of these programs may be to increase the number of providers who elect to practice in underserved areas. Two programs in New York account for 80 percent of the total identified minority participants: a program at the Sophie Davis School of Biomedical Education and also the Regent Health Care Scholarship Program limit eligibility to those from disadvantaged areas and populations, and those from underrepresented minority groups.

2. Affecting Experiences during the Educational Process

State programs have also attempted to influence specialty and location choices during the educational process. They have increased the resources available to primary care (and thus perhaps its professional standing), supported public medical schools, and sponsored changes in curriculum which increase students' exposure to both primary care and underserved areas.

a. Increasing the resources available to primary care

Resources available to primary care are provided through support for primary care residencies, preceptorships, and grants for research in primary care. Private foundations such as Kellogg and Robert Wood Johnson provide direct grants to primary care residencies and offer clinical fellowships in family medicine to qualified health professionals. These programs attempt to induce providers to choose primary care specialties by incorporating primary care in their educational experience and by augmenting the status of primary care.

³ In the state programs identified, selective recruitment is always combined with some other strategy. The programs were classified under the second strategy for purposes of data analysis and display, so that "Selective Recruitment" does not appear as a strategy in the tables.

⁴ Gray, L.C. "The Geographic and Functional Distribution of Black Physicians: Some Research and Policy Implications." American Journal of Public Health 67 (June 1977): 519-26.

Many states, such as New York, California, and Michigan, have provided subsidies to family practice residency programs,⁵ initially to stimulate the development of additional training programs and more recently to maintain enrollment levels. Patient revenues account for only about 31 percent of the average cost per family practice resident, according to a new national study of 1981-82 cost and funding levels,⁶ thus necessitating continued reliance on other subsidies.

Eleven states (California, Georgia, Illinois, Iowa, Kentucky, Michigan, New Jersey, Oklahoma, Oregon, Texas, and Washington) have developed programs with a distributional focus in addition to providing subsidies for family practice residency programs. One approach is the Michigan Family Practice Residency Program, which provides subsidies through project grants targeted to programs which serve urban poverty areas or medically underserved areas, and to those which actively recruit minority and women physicians. By targeting residencies in underserved areas, program officials believe there is a greater likelihood that graduates will choose to practice in underserved areas.

Several programs of grants to primary care residencies measure outcomes as the number of graduates who practice in the state or a designated area in the state. Generally, programs supporting primary care residencies reported that the majority of graduates practice in the state. The Michigan, New York and Texas Family Practice Residency Programs reported that between 70 and 80 percent of graduates remained in the state. One exception is the Illinois Family Practice Residency Act Scholarship Program. Illinois program officials reported that many of the program participants eventually practice outside the state. Reasons for the differences in outcomes among programs are uncertain, since there is little variation in program structure across states.

b. Supporting public medical schools

Thirty-nine states have public medical schools, a sign of their commitment to medical education. The graduates of public medical schools are more likely to enter primary care in underserved areas than are graduates of private medical schools. Since 1970 ten new medical schools have become operational; of these, seven are public. Most of them, such as East Carolina

⁵ The Compendium includes only those 11 primary care residency programs that also have a targeted geographic distribution focus. Four programs in Florida, Kansas, Massachusetts, and New York without such a focus are included since they had been discussed in the 1981 Compendium.

⁶ E.W. Ciriacy, "The Cost and Funding of Family Practice Graduate Education in the United States," Journal of Family Practice 20.3 (1985): 285-95.

⁷ Otis, G.D.; Graham, J.R.; and Thacker, L. "Typological Analysis of U.S. Medical Schools." Journal of Medical Education 50 (April 1975): 328-38.

⁸ American Medical Association. "Medical Education in the United States, 1978-1979." Journal of the American Medical Association 243 (March 7, 1980): 835-984.

University, were designed to afford educational opportunities for areas of the state with few such opportunities, as well as to produce more primary care physicians for rural areas. Since the states' payments to these schools are largely general support for health professions education and only secondarily for their distributional effects, these subsidies are excluded from the Compendium. However, many of the targeted distributional programs are sponsored by public institutions; these programs are discussed under the appropriate category.

c. Purchasing seats in health professions schools

While 39 states support their own public medical schools, 8 others prefer to purchase seats in out-of-state health professions schools to enable state residents to attend those schools. They may be regional agreements between individual states and one or more medical schools (Maine, Massachusetts, Rhode Island, and Wyoming), or several states supporting one medical school (Alaska, Idaho, Montana, and Washington). Three of these programs (Maine, Massachusetts, and Wyoming) require a commitment to return to the state to practice for a period of time. Thus they overlap with another major strategy, that of financial incentives. Seat purchase programs without a service component are primarily designed to provide access to medical education for residents of states without medical schools. State officials believe that by providing educational opportunities for state residents, some of these students will return to their home state to practice.

One well-known seat purchase program is WAMI, created in 1971 by Washington, Alaska, Montana, and Idaho. Its major purposes are to increase the number of medical graduates from the last three states, which have no medical schools, and to increase the number of primary care practitioners in the four-state area.

Four of eight seat purchase programs reported outcomes. In this small sample, seat purchase programs with a service commitment appear to have a greater proportion of students who return to practice in the state than seat purchase programs without a service commitment. The Maine and Wyoming programs, which require service in-state after training, report that 75 percent of program participants return to practice in the state. In contrast, two of the states participating in WAMI, which does not require service in state, reported in one case (Montana) that only 60 percent return to the state, while in another (Alaska) 44 percent return.

d. Sponsoring changes in curriculum

Curriculum changes are intended to provide alternatives to the traditional hospital-focused medical education experience in order to influence provider preferences through exposure to certain specialties or geographic areas. The experiences may attract students previously uncertain about their career choices or may help students to maintain their interests and confirm previous choices. Of the 18 programs identified in 10 states (Kansas, Kentucky, Michigan, Minnesota, New Hampshire, New Mexico, New York, Ohio, Pennsylvania, and Tennessee), most are designed to place undergraduate medical students into preceptorships with community physicians, usually in rural areas. The program directors express belief that many students find the experience so satisfying that they decide to practice in the same or similar

locations. The preceptor experience varies across programs. Some programs offer long rotations with the belief that a preceptorship experience of several months to a year provides a more realistic practice experience than a shorter rotation. Other programs require several preceptor rotations over the course of a student's medical education. These latter program officials believe that repeated contact with rural practitioners throughout the medical education process is more likely to influence provider location choice than one rotation. Finally, a few preceptorship programs attempt to actively integrate the student into the community.

Minnesota's Rural Physician Associate Program is an example of an effort designed to increase students' exposure to rural primary care through one nine-to-twelve-month preceptorship. Third-year medical students work under the guidance of family physicians, and by the end of the period they are providing basic health care under supervision. The program's director reported that of the 400 students who have participated, more than 60 percent eventually selected rural family practice after completing their residencies. He attributed this positive outcome both to the quality of the experience and its length; preceptorships elsewhere are frequently of much shorter duration, often as little as one month as they are in Kansas and New Mexico.

The Michigan Preceptorship and Junior Partnership Program is an example of an effort to provide early and continuous exposure in family practice. All students are required to rotate through four preceptorship experiences in their second year of medical school, spending one afternoon per week in each of four terms. In their last two years of medical school, students complete two full-time, six-week rotations with a family physician. These clinical experiences are intended to provide students with a realistic view of what it means to be a family physician.

The Appalachian Student Health Coalition in Tennessee is a preceptorship program which focuses on community involvement in addition to clinical experience. Students spend a summer in local communities where they coordinate health fairs and other activities designed to increase health awareness. They provide free physical examinations, and in-home follow-up services to people in medically underserved areas. Program officials believe that students thus integrated into the community are more likely to choose the community for their practice site.

Few preceptorships provided a quantitative measure of program success or failure. Instead, these preceptorship programs are usually evaluated by qualitative measures assessing the students' experience in the preceptorship. Students are asked to rate the quality of their experience and preceptors are asked to evaluate the students' level of effort. Administrators of many of these programs, such as the Pennsylvania Primary Care Preceptorship Program, the Pennsylvania College of Osteopathic Medicine Preceptorship Program, and the Greater Mohawk Valley (New York) Regional Medical Education Alliance, reported that students are enthusiastic about their preceptorship experience. Other programs, such as Minnesota's, track the eventual practice specialties location of their participants. The University of New Mexico, which requires all students to serve a preceptorship in the fourth year, reported that 58 percent of the 1984 graduates and 68 percent of the 1985 graduates selected primary care residencies. The Clinical Branch Campus at the State University of New York-Binghamton, beginning in 1986, will have medical students assigned

by lottery from the Syracuse campus, thus providing a future opportunity to evaluate the effect of the decentralized training experience on students who may or may not be predisposed to practice in less urbanized areas.

While preceptorship programs account for the majority of curriculum changes, states have pursued other innovations, mainly enrichment programs to increase the number of health professionals from minority or rural backgrounds. Program administrators believe that these students are more likely to choose primary care or to practice in an underserved area.

The Kentucky Professional Education Preparation Program is an example of an enrichment program. It awards grants to educational institutions to increase the number of individuals from health manpower shortage areas who are accepted to and succeed in medical and dental schools. Students are taught study skills, receive some clinical experience, and receive preparation for professional school admissions tests. Program officials maintain contact with students through their application to medical school, and follow up with students who are accepted to and enroll in medical school. Officials believe that early and continued contact is directly related to students' success in medical school and in influencing their practice location.

Area Health Education Centers (AHECs) are another large-scale effort to support training outside of major academic medical centers. The 12 AHECs in the Compendium, originally federally funded but now largely supported by states, are centered in medical schools and have links to remote practice sites designed to provide decentralized training and continuing education and support to practicing physicians. The AHECs in Arizona, Kansas, Kentucky, Massachusetts, Maine, North Carolina, Oklahoma, South Carolina, Tennessee, Virginia, and West Virginia attempt to alter preferences through exposure to rural medicine as well as through minimizing isolation through continuing medical education and links with medical schools.

The Massachusetts Statewide AHEC, established in 1973, sponsors off-campus education for undergraduate medical schools in a variety of practice settings; supports residencies in primary care in both rural and inner city hospitals; assists in minority recruitment activities at the University of Massachusetts Medical Center; supports dentistry preceptorships and residency programs in Boston; supports nursing and allied health education; and provides continuing medical education at six sites throughout the state.

In addition to providing decentralized training opportunities and continuing medical education, some AHECs have adopted creative strategies to meet the health resource needs of the state. For example, two AHECs in Maine have expanded their focus in an attempt to retain health providers in the state. The Maine statewide AHEC has adopted special initiatives to educate physicians, dentists, and nurses about social medicine issues, such as alcoholism and teenage pregnancy. The University of New England College of Osteopathic Medicine AHEC, also in Maine, is focusing on developing a greater

⁹ AHECs serve dual roles; in addition to decentralized training, many AHECs provide continuing medical education and offer assistance to practicing providers.

cultural understanding among existing professionals about the populations they are serving. Another approach is that of the Oklahoma AHEC, which coordinates summer internships with Native American physicians for Native American undergraduate allopathic or osteopathic students to introduce them to clinical practice.

Some program administrators believe that the involvement of community physicians in preceptorships, AHECs, and other decentralized educational programs has at least as important influence as any experience upon the students' specialty and location choices. Improvements in accessibility and quality of care as well as in retention of physicians in underserved communities have been attributed to participation of community physicians in such medical training. Many physicians serve as adjunct faculty without compensation since budgetary cutbacks in medical schools have deleted funding for honoraria and stipends, although access to continuing medical education is usually a fringe benefit.

3. Financial Incentives to Locate in Certain Areas

The most common state approaches to distributional problems are financial incentives to health professionals to locate in certain areas, similar to the federal National Health Service Corps (NHSC) scholarship program. Of the 113 state programs identified in the Compendium, financial incentives account for 39 programs in 26 states (Alabama, Alaska, Arizona, Arkansas, Georgia, Illinois, Kansas, Kentucky, Maine, Maryland, Massachusetts, Mississippi, Missouri, Nevada, New Mexico, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, Texas, Virginia, Washington, West Virginia, and Wyoming). These financial incentives may take the form of loans, scholarships, or grants. Thirty-five programs require that recipients serve in shortage areas, much like the federal NHSC ("service-contingent" programs), or else offer service as an alternative to cash paybacks ("service-forgiveness" programs).

Service-contingent programs vary in the amount of financial aid available, the service requirements, and the buyout provisions. Penalties for repaying the financial aid instead of fulfilling the service obligation range from lenient to strict. Lenient buyout provisions entail a straight repayment of the loan at a subsidized interest rate over a 10-year period. Strict buyout provisions impose additional penalties such as a required payment three times the principal or immediate repayment.

These service-contingent programs serve the dual purpose of giving educational opportunities to state residents while providing exposure to specific geographic areas with the goal of influencing the practice preferences of the providers. In effect, the programs purchase providers to practice for a limited time in an area to meet the population's immediate needs with the hope that practitioners will remain there after their service requirements are completed.

One program provides an interesting lesson in the efficacy of service-forgiveness loans. The North Carolina Student Loan Program, operational since 1945, until 1983 offered forgiveness of loans if recipients served in designated shortage areas. This program showed good results: as of March 1984, 58 percent of dentists, 71 percent of primary care physicians, 80

percent of optometrists, and 31 percent of pharmacists were still practicing in the county where they did their initial practice. However, in 1983, the program dropped the forgiveness provision, becoming a straight loan program with only cash paybacks. The altered program neither attracted new students, since it could not compete with other loans having more favorable terms, nor could it provide incentive to attract students to underserved areas. Responding to these problems, the state legislature has restored the loan forgiveness provisions.

Rather than directly supporting students, another approach is working with local communities to secure health professionals for that community. The Oklahoma Community Physician Education Scholarship Loan Program matches communities on a 50-50 basis to provide financial aid for students attending medical school in return for an agreement to return to practice in that community. Program officials reported that the program is successful because students interact with their communities during their training experience and develop ties to the community.

The evaluation measure used by states to assess their service-contingent programs is the percent of program participants who complete their service requirement rather than "buying out" of their obligations by repaying the funds. Since these programs must often report outcomes to the state legislature as justification for continued support, they are more likely to report outcomes than are other programs.

Several factors contribute to whether or not students in service-contingent programs fulfill their practice obligations. Among these are the leniency or stringency of the buyout provisions and the affinity of the student toward practice in an underserved community. Those 15 programs with strict buyout provisions, such as high interest rates and penalties, tend to have the greatest number of physicians and dentists fulfilling their obligation. Two programs illustrate examples of high penalties for buyout associated with high success rates. The Georgia State Medical Education Board Scholarship Program's penalty for buyout is three times the principal and accrued interest. The program reported in 1986 that 70 percent of participants fulfill their obligations. Another example is the Illinois Medical Student Loan Fund, administered by the Illinois Farm Bureau and the Illinois Medical Society, where the penalty for non-service is liquidated damages and interest, payable immediately. Approximately 80 percent of participants fulfill their obligations.

A state-by-state comparison of the number of medical students participating in service-contingent programs, as well as those participating in such programs with strict buyout provisions, is shown in Table 2. The table also shows that, while 2,217 students are participating in service-contingent programs, only 454 students face stiff penalties if they choose to repay the loan or scholarship rather than serving in shortage areas.

Strict buyout penalties seem to help induce health professionals to serve in shortage areas, but other factors may also be important, as shown by the fact that two programs with lenient penalties have mixed results. The Kansas Medical Scholarship Program provides scholarships to students who agree to practice primary care anywhere in the state for one year for each year of scholarship. Penalty for buyout is principal plus 15 percent

Table 2
MEDICAL STUDENT PARTICIPANTS IN SERVICE-CONTINGENT PROGRAMS

STATE	PARTICIPANTS	PARTICIPANTS IN STRICT BUY-OUT PROGRAMS*
<u>REGION I</u>		
Connecticut		
Massachusetts	400	
Maine	25	
New Hampshire		
Rhode Island		
Vermont	—	—
TOTAL REGION I	425	0
<u>REGION II</u>		
New Jersey		
New York	**	—
TOTAL REGION II	0	0
<u>REGION III</u>		
Delaware		
District of Columbia		
Maryland	192**	4
Pennsylvania		
Virginia	33	
West Virginia	16	—
TOTAL REGION III	241	4
<u>REGION IV</u>		
Alabama	**	
Florida		
Georgia	34	34
Kentucky	24	24
Mississippi	60	60
North Carolina	360	
South Carolina	37	37
Tennessee	—	—
TOTAL REGION IV	515	155
<u>REGION V</u>		
Illinois	75	59
Indiana		
Michigan		
Minnesota		
Ohio	65	65
Wisconsin	—	—
TOTAL REGION V	140	124

Table 2 (Continued)
MEDICAL STUDENT PARTICIPANTS IN SERVICE-CONTINGENT PROGRAMS

STATE	PARTICIPANTS	PARTICIPANTS IN STRICT BUY-OUT PROGRAMS*
<u>REGION VI</u>		
Arkansas	61	61
Louisiana		
New Mexico	49	25
Oklahoma	51	8
Texas	<u>51</u>	<u>51</u>
TOTAL REGION VI	212	145
<u>REGION VII</u>		
Iowa		
Kansas	365	
Missouri	8	8
Nebraska	<u>34</u>	<u>—</u>
TOTAL REGION VII	407	8
<u>REGION VIII</u>		
Colorado		
Montana		
North Dakota		
South Dakota		
Utah		
Wyoming	<u>95</u>	<u>—</u>
TOTAL REGION VIII	95	0
<u>REGION IX</u>		
Arizona	176	18
California		
Hawaii		
Nevada	<u>—</u>	<u>—</u>
TOTAL REGION VIII	176	18
<u>REGION X</u>		
Alaska	**	
Idaho		
Oregon		
Washington	<u>6</u>	<u>—</u>
TOTAL REGION X	6	0
TOTAL	2,217	454

* Strict Buy-out programs are those which impose a penalty of greater than 150 percent of principal or require immediate repayment.

** State has programs not reporting. Thirty programs reporting participants; 35 programs total.

interest, payable over 10 years. Only 40 percent of the participants fulfill their obligations, resulting in the state's recent diminished funding for the program. In contrast, the Maine Postgraduate Health Professions Program purchases seats at Tufts and the University of Vermont. Students may repay the cost through service in a designated area of the state for one year for each year of aid. Penalty for buyout is principal plus 9 percent interest, payable over 10 years. Despite this lenient penalty, 75 percent fulfill their obligations. Maine program officials speculate that the success of the program may be because some participants also have NHSC scholarships and return to Maine to fulfill both service obligations. In addition, they believe program participants may have originally intended to return to Maine.

Selectively recruiting individuals with a preference for rural practice is a way to increase the number of students who fulfill their obligations. The Nebraska Medical Student Loan Program is an example of a service-contingent program that selectively recruits those most likely to enter rural practice. The program provides low interest loans for residents of Nebraska to attend medical school in return for one year of service for each year of support. Evidence of a life history in rural Nebraska and other ties to such areas are weighted heavily in determination. The presence of lenient buyout provisions with 84 percent service completion suggests that selective recruitment is a large factor in the success of this program.

Policymakers and program managers who wish to examine the experiences of their own and other states find three problems with using only the proportion of participants who fulfill their service obligations to evaluate the success of service-contingent programs:

- States may set lenient buyout provisions for student financial aid because a major goal is not affecting health professionals' distribution, but rather reducing financial barriers to medical education. Using the buyout rate as a measure of the programs' success or failure may overemphasize the distribution effects and underemphasize the financial aid goals.
- Programs seldom measure the retention rate of those health professionals who have completed their service obligations, that is, those who choose to remain in their service sites.
- The measure does not correct for self-selection, that is, the number of students who would have chosen to practice in underserved areas even without the financial incentive. It is therefore difficult for managers to know how many students the program enabled to complete their educations and practice in underserved areas as well as how many additional students the program attracted to shortage areas.

Service-contingent programs appear to be an effective way to place health professionals in underserved areas. High penalties for buyout and selective recruitment of individuals with a preference for rural practice contribute to the success to these programs.

4. Aid in Establishing and Maintaining Practices

The programs described thus far largely direct their efforts at recruiting, training, or supporting students during the educational process. Other programs direct their efforts at recruiting and retaining health professionals after they have completed their medical education, using different approaches to aid in establishing and maintaining practice. Thirty-two programs in 20 states (Arkansas, California, Florida, Georgia, Kansas, Kentucky, Maine, Massachusetts, Michigan, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, Tennessee, Utah, Virginia, West Virginia, and Wisconsin) are designed to assist either underserved communities wishing to attract physicians or the physicians to find communities where they can establish practices.

Some programs establish a computerized list of places to be matched with health professionals, but do not attempt to assist the physicians in establishing practices. Other programs aid health professionals in locating, establishing, and maintaining practices through financial and/or technical assistance often coordinated by creating a primary care infrastructure. Few programs aiding physicians in establishing practice quantitatively measure outcomes. However, program administrators believe that a successful approach combines recruiting and placement services with development of a community infrastructure to give ongoing support to physicians.

Some placement services maintain computerized lists of places to be matched with health professionals and attempt to influence the physician market by providing more complete information about practice opportunities. These programs are found in Arkansas, Florida, Georgia, Kansas, Massachusetts, Michigan, North Dakota, Oklahoma, South Carolina, Utah, Virginia, and Wisconsin. In general, these services do not evaluate outcomes. However, the Kansas Physician Placement Program and the Michigan Health Council Physician Placement Service reported that they place 25 and 50 physicians per year, respectively.

Three programs offer direct financial aid to a new physician or practice site either in the form of loans to establish a practice or guaranteed income to support a practice. These programs are found in California, Nevada, and New Mexico. Frequently the health professionals placed have obligations from either NHSC or state service-contingent programs. For example, the Central Nevada Rural Health Consortium provides income subsidies to physicians and other health professionals to practice in one of eight health clinics. Their evaluation measure is the percent of health professionals who remain in the clinic. To date, one physician and all the physician's assistants supported by the program have remained in the clinics. Another program providing financial assistance in establishing a practice is the New Mexico physician loan program, sponsored by a nonprofit multihospital corporation, which provides interest-free loans of up to \$125,000 during the first year of practice. The program, which has recruited physicians since 1978, reports a retention rate of over 90 percent.

Two programs in Kansas and New Mexico attempt to establish coordinated infrastructures but do not provide financial assistance. New Mexico Health Resources, Inc., a private organization, has coordinated an infrastructure to provide technical assistance to providers in locating and maintaining

their practices. The program builds upon the existing primary care networks in the community. It operates a recruiting system that helps communities attract health professionals. Once a provider is in place in a rural community, the program seeks to promote long term retention of those recruited by providing technical and management assistance.

Other programs attempt to build a community infrastructure to provide assistance in establishing practice and ongoing support in maintaining practice. These three programs in Arkansas, North Carolina, and Oregon rely on a combination of financial and technical assistance or technical assistance alone. For example, North Carolina's Office of Rural Health Services has concentrated on developing the rural delivery infrastructure into which physicians can be placed. It provides technical, operating, and capital assistance to community-sponsored health centers, which are eventually expected to become self-supporting. During the 1970s, the office concentrated on locating and training nurse practitioners to staff these centers, but the increasing physician supply of the 1980s has made recruitment of physicians much easier. During the past 10 years, the Office has placed 594 physicians, of whom 60 percent of all private placements in practice for at least 5 years have remained at the placement site. The Arkansas Office of Rural Health offers a similar program modeled on the North Carolina approach, but it makes low-interest loans directly to the participating physicians.

The effectiveness of programs that assist health professionals in establishing and maintaining practice in underserved areas appears to depend on the level of ongoing support provided. Programs that provide financial assistance in setting up a practice as well as technical and management assistance in maintaining that practice are better able to retain providers in underserved areas than programs more limited in scope such as computerized placement lists.

B. WHAT IS THE STATE LEVEL OF EFFORT IN HEALTH PROFESSIONS DISTRIBUTION PROGRAMS AND HOW HAS THIS CHANGED SINCE 1981?

1. Current Level of Effort

States vary greatly in the number of programs they have, the available funding, and the number of program participants (see Table 3). Nine states have no programs whose major goal is the distribution of health professionals: Colorado, Connecticut, Delaware, District of Columbia, Hawaii, Indiana, Louisiana, South Dakota, and Vermont. In contrast, 11 states report 4 or more programs, usually with hundreds of participants: Arkansas, Kansas, Kentucky, Maine, Massachusetts, Michigan, New Mexico, New York, Oklahoma, Pennsylvania, and Texas. Funding levels varied from \$0 to \$35,168,000. Clearly, states differ in their commitment to health distribution programs.

The 101 programs reporting funding levels stated that they had \$170,791,000 available in 1985 to support their programs. As Exhibit 2 shows, the programs reporting the highest funding levels were primary care residencies and AHECs, both of which directly subsidize expensive graduate medical education. The service-contingent loans and scholarships reported \$13,523,000 in funds.

Table 3
STATE LEVELS OF EFFORT
1985

STATE	PROGRAMS	FUNDING ¹ (\$000s)	PARTICIPANTS ²
<u>REGION I</u>			
Connecticut	0	\$ 0	0
Maine	5	1,148*	55*
Massachusetts	5	2,585*	418*
New Hampshire	1	0*	240
Rhode Island	1	302	128
Vermont	<u>0</u>	<u>0</u>	<u>0</u>
Total Region I	12	\$ 4,035	841
<u>REGION II</u>			
New Jersey	1	365	0*
New York	<u>7</u>	<u>11,569*</u>	<u>1,174*</u>
Total Region II	8	\$11,934	1,174
<u>REGION III</u>			
Delaware	0	0	0
District of Columbia	0	0	0
Maryland	4	170*	314*
Pennsylvania	5	478*	353*
Virginia	3	1,258	33*
West Virginia	<u>2</u>	<u>124</u>	<u>16*</u>
Total Region III	14	\$ 2,030	716
<u>REGION IV</u>			
Alabama	1	0*	0
Florida	2	5,331	351*
Georgia	3	5,302	307
Kentucky	4	5,198	193*
Mississippi	1	150	60
North Carolina	3	25,937	432*
South Carolina	3	25,644	37*
Tennessee	<u>2</u>	<u>384</u>	<u>27</u>
Total Region IV	19	\$67,946	1,407
<u>REGION V</u>			
Illinois	3	1,032	75
Indiana	0	0	0
Michigan	5	1,464*	72*
Minnesota	2	425*	24*
Ohio	2	0*	145
Wisconsin	<u>1</u>	<u>0*</u>	<u>0*</u>
Total Region V	13	\$ 2,921	316

Table 3 (Continued)
STATE LEVELS OF EFFORT
1985

STATE	PROGRAMS	FUNDING ¹ (\$000s)	PARTICIPANTS ²
<u>REGION VI</u>			
Arkansas	4	\$ 570*	69
Louisiana	0	0	0
New Mexico	6	4,370	179*
Oklahoma	6	5,630*	164*
Texas	<u>4</u>	<u>35,168*</u>	<u>521*</u>
Total Region VI	20	\$45,738	933
<u>REGION VII</u>			
Iowa	1	1,393	180
Kansas	7	4,347*	570*
Missouri	1	50	8
Nebraska	<u>1</u>	<u>231</u>	<u>34</u>
Total Region VII	10	\$ 6,021	792
<u>REGION VIII</u>			
Colorado	0	0	0
Montana	1	2,374	80
North Dakota	1	648	0*
South Dakota	0	0	0
Utah	1	0*	0*
Wyoming	<u>1</u>	<u>2,774</u>	<u>95</u>
Total Region VIII	4	\$ 5,796	175
<u>REGION IX</u>			
Arizona	2	1,955	176
California	2	2,980	3*
Hawaii	0	0	0
Nevada	<u>1</u>	<u>1,000</u>	<u>8</u>
Total Region IX	5	\$ 5,935	187

Table 3 (Continued)
STATE LEVELS OF EFFORT
1985

STATE	PROGRAMS	FUNDING ¹ (\$000s)	PARTICIPANTS ²
<u>REGION X</u>			
Alaska	2	\$ 1,679	48*
Idaho	1	2,356	74
Oregon	2	1,222	14*
Washington	<u>3</u>	<u>13,178</u>	<u>128*</u>
Total Region X	8	\$18,435	264
TOTAL	113	\$170,791	6,805

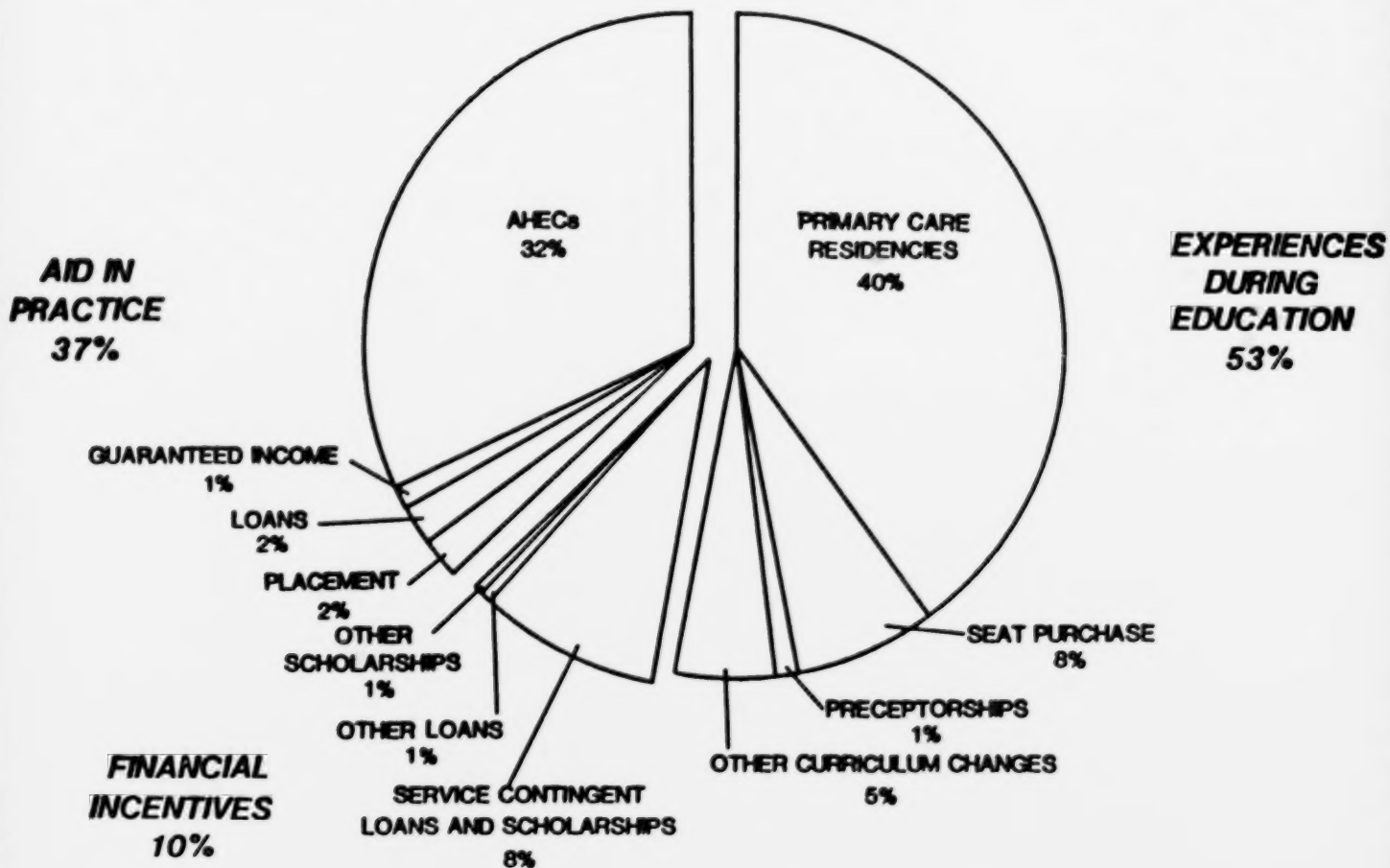
¹ All programs, all sources (federal, state, local, private); 101 programs reporting.

² 75 programs reporting. Many AHECs and placement services did not report participants.

* State has programs not reporting.

EXHIBIT 2

1985 FUNDING LEVELS BY PROGRAM TYPE⁽¹⁾



(1) TOTAL FUNDING REPORTED BY 101 PROGRAMS: \$170,791,000

State appropriations represent the primary, but not the only, source of funding for programs identified in this study. On average, state funds represent 76 percent of total budgets, federal funds 11 percent, local funds 6 percent, and private funds 7 percent. Fifty-five programs are funded solely from state appropriations. The proportion of state funding varies across program types, with service-contingent and seat purchase programs having the highest proportion of state funds.

The states' differing levels of effort in health distributions programs may arise from a variety of factors, including:

- The presence or absence of large numbers of underserved people in the state.
- The degree of rurality.
- The commitment to health professions education in general.
- The numbers of medical school places, particularly those in public institutions or those in private institutions heavily subsidized by the state.
- The state's fiscal climate.
- The political ideology currently in power.

The primary reason for variations in state level of effort may relate to differences in the need for health professionals. To examine the relationship between a state's effort and need based on the first two factors on the above list, the study looked at the states' efforts (as measured by relative funding and participant levels) compared to two measures: their unserved populations and their non-metropolitan populations (see Table 4). The unserved populations are those people living in federally designated Health Manpower Shortage Areas (HMSAs) who are estimated by the Bureau of Health Professions to be lacking available primary care. The percentage of non-urban population is a measure of the state's rurality. No clear pattern emerges.

In slightly over half the states, the level of effort is closely related to these two measures of need for health distributions programs. For example, Kentucky demonstrates a high level of effort as measured by the number of distribution programs, funding levels, and number of participants. Its four programs include an enrichment program to prepare disadvantaged students for medical school, a service-contingent program obligating students to rural practice, an AHEC, and support for family practice residency programs. With respect to need, according to 1985 BHPr data, Kentucky has one of the highest numbers of unserved residents in the United States. Connecticut is another example of state level of effort closely related to need measures. The state has no health professions distribution programs and one of the lowest unserved population measures in the U.S. The state has one publicly supported medical school and may be providing support for health professions through the medical school.

Table 4
STATES' LEVEL OF EFFORT COMPARED
TO THEIR UNSERVED AND NON-URBAN POPULATIONS

STATE	LEVEL OF EFFORT ¹	UNSERVED POPULATION ²	PERCENT NON- URBAN POPULATION ³
<u>REGION I</u>			
Connecticut	4	70	21.2%
Massachusetts	2	49	52.5
Maine	2	218	16.2
New Hampshire	4	24	47.8
Rhode Island	3	31	13.0
Vermont	4	31	66.2
<u>REGION II</u>			
New Jersey	4	187	15.3
New York	1	562	19.4
<u>REGION III</u>			
Delaware	4	18	29.4
District of Columbia	4	65	0.0
Maryland	2	177	19.7
Pennsylvania	3	558	30.7
Virginia	2	283	34.0
West Virginia	4	282	63.8
<u>REGION IV</u>			
Alabama	4	362	40.0
Florida	1	608	15.7
Georgia	1	592	35.8
Kentucky	1	247	49.1
Mississippi	4	395	52.7
North Carolina	1	461	52.0
South Carolina	2	253	45.9
Tennessee	3	291	39.6
<u>REGION V</u>			
Illinois	3	909	16.7
Indiana	4	210	35.8
Michigan	3	353	29.3
Minnesota	4	73	33.1
Ohio	3	554	26.7
Wisconsin	4	273	35.8
<u>REGION VI</u>			
Arkansas	3	177	48.4
Louisiana	4	551	31.2
New Mexico	3	230	27.9
Oklahoma	1	111	32.7
Texas	1	864	20.4

Table 4 (Continued)
**STATES' LEVEL OF EFFORT COMPARED
 TO THEIR UNSERVED AND NON-URBAN POPULATIONS**

STATE	LEVEL OF EFFORT ¹	UNSERVED POPULATION ²	PERCENT NON- URBAN POPULATION ³
REGION VII			
Iowa	3	78	41.4%
Kansas	1	33	33.3
Missouri	4	444	31.9
Nebraska	4	60	37.1
REGION VIII			
Colorado	4	66	19.4
Montana	2	70	47.1
North Dakota	3	68	51.2
South Dakota	4	84	53.2
Utah	4	61	15.6
Wyoming	2	38	37.3
REGION IX			
Arizona	2	135	16.2
California	2	751	8.7
Hawaii	4	18	13.5
Nevada	4	76	14.7
REGION X			
Alaska	3	74	35.7
Idaho	2	128	46.0
Oregon	3	164	32.1
Washington	1	126	26.5

¹ Level of effort is derived from a combination of three variables: number of programs, funding, number of participants. The scale ranges from 1, high level of effort, to 4, little or no level of effort.

² In thousands. The estimated unserved population is computed by multiplying the number of practitioners in the area by the population to practitioner ratio and subtracting the figure from the area population.

³ Percent of population in non-urban areas, 1980 Census.

For the other half of the states, need and level of effort do not match well. Explanations for the states' high or low levels of effort may be explained by other factors such as budgetary constraints and the political climate. For example, Louisiana has a large unserved population, but no health professions distribution programs. Possible explanations for this disparity are state budgetary constraints and the political climate. On the other hand, Kansas has a high level of effort in health professions distribution programs, but low measures of need. Program officials in Kansas reported that these programs are being phased out because the need for additional health professionals is declining.

Information about the states' commitment of resources to health professions education in general, as well as the available medical school places will be available in late 1986 from Mandex, Inc., a consulting firm that is conducting a study for the Bureau of Health Professions.

2. Trends in Level of Effort since 1980

Financial support for non-federal health professions distribution programs has increased substantially between 1980 and 1985.¹⁰ Exhibit 3 shows changes in funding levels and sources for the 68 programs reporting both items in 1980 and 1985. In nominal dollars, total support from all sources increased from \$41.6 million in 1980 to \$72.7 million in 1985, a 75 percent increase in funding. After adjusting for inflation, total support from all sources increased to \$51.6 million in 1985, a 73 percent increase in state funding. In nominal dollars, funding from state sources increased from \$39.1 million in 1980 to \$67.6 million in 1985. After adjusting for inflation, the state funds in 1985 totaled \$48.0 million. The percentage distribution of funds from federal, state, local, and private sources remained essentially the same between 1980 and 1985.

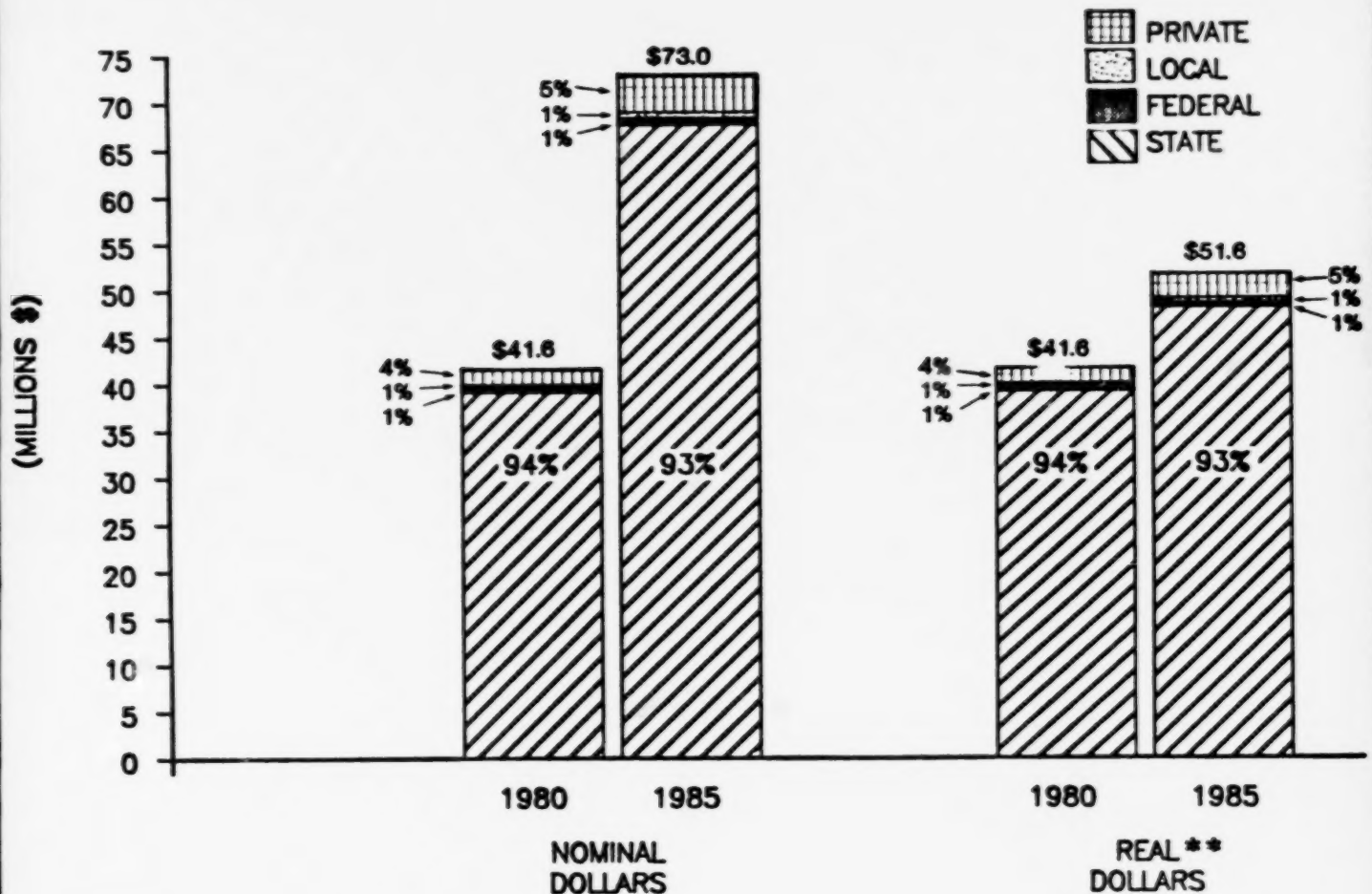
The updated Compendium identifies 38 programs that have been discontinued since 1981. This number includes programs which were verified as having been discontinued and programs listed in the 1981 Compendium that could not be traced through contact with appropriate state agencies and private institutions. No patterns seem to exist regarding the geographic distribution or type of discontinued program. Seventeen of these programs were defunded and not replaced. Interviewees reported a loss of funding, but the reasons for the loss varied. In some cases, such as Indiana and Louisiana, defunding was caused by a loss of political support as the physician supply increased. In other cases, such as Michigan, state fiscal crises forced abandonment of programs.

Since 1981 eleven new programs have been established. Four programs replaced discontinued programs; the others were added to existing state programs. Maine, Oklahoma, and Tennessee created AHECs; South Carolina established a placement service to attract physicians to rural areas; New Mexico established a loan program for practicing providers; Texas and Oklahoma established service-contingent programs; in Michigan one nongovernment graduate

¹⁰ The Compendiums, while dated 1981 and 1986, reflect a one-year lag in funding data.

EXHIBIT 3

FUNDING LEVELS AND SOURCE OF FUNDING*



* 68 PROGRAMS REPORTED FUNDING LEVELS AND SOURCES IN 1980 AND 1985
 ** ADJUSTED FOR INFLATION

medical education planning body was replaced by another which excluded representatives of Blue Cross/Blue Shield and the state health planning office who had served on the predecessor organization; in West Virginia, a service-contingent program replaced an existing one.

New York replaced its Regents Physician Shortage Scholarship Program with two programs, the Regents Health Care Scholarships and the Regents Loan Forgiveness Program. The latter program provides financial assistance only after the physician has completed training and has entered practice in an underserved area. Changes in the New York programs since 1980 include more stringent buyout and penalty provisions, substitution of loan buyout to new practitioners instead of upfront financial aid to medical students during their training, and limiting service-conditional scholarship assistance to underrepresented minorities with financial need. This approach has the advantage of recruiting physicians on an as-needed basis, avoiding the risk implicit in service-contingent undergraduate medical student assistance of miscalculating future need. However, a loan forgiveness program assumes that students will be able to access the capital market to finance undergraduate medical education.

Trends in the number of participants from 1980 to 1985 are mixed. Of the 31 programs reporting program participants in both years, 16 experienced a decrease in participants while 12 experienced an increase. Service-contingent programs account for the majority of programs which decreased in number of participants. For example, the Kansas Medical Scholarship Program, which is being phased out, has significantly decreased the number of participants. The Arizona Western Interstate Commission on Higher Education significantly increased the number of participants and is directing the program toward health professionals other than physicians.

Overall trends in health professions distribution programs between 1980 and 1985 were mixed, as individual states tailored their efforts to internal manpower, budget, and political circumstances. The absence of national trends may indicate lack of change in the perceptions of policies of states toward health professions distribution.

C. WHAT CAN POLICYMAKERS LEARN FROM THE STATE INITIATIVES?

Policymakers are interested in how well state initiatives address health professions distributions problems. While the study did not attempt to evaluate the programs, it did collect information on program outcomes and evaluation measures as reported by program administrators. Outcome information was available from only 49 programs (44 percent). Fifty-two programs do not have an evaluation component, and 11 are too new to report program outcomes. The most reliable outcome information is from service-contingent programs, since many other programs give only limited attention to program evaluation.

The outcomes of health professions programs are mixed, since there are so many factors affecting provider specialty and location choice. Nonetheless, several lessons can be learned from examining state initiatives in health professions distribution. The lessons are:

- Integrated multiple strategies have a better chance of success in attracting and retaining health professionals in shortage areas than does a single strategy.
- Service-contingent programs are an effective but expensive method to place health professionals; preceptorships and other curriculum changes are significantly less expensive but may not be as effective.
- Service-contingent programs with high penalties for buyout are an effective means of temporarily recruiting health professionals to shortage areas. However, more permanent retention of physicians in these areas may require additional commitment of programs and resources.

This section discusses each of these lessons in turn.

1. Integrated multiple strategies have a better chance of success in attracting and retaining health professionals in shortage areas than does a single strategy.

Most of the programs identified in the Compendium have tended to focus on a single strategy for attracting health professionals to shortage areas. They tend to concentrate, for example, on introducing undergraduate medical students to the attractions of rural practice through preceptorships or they match communities needing physicians with the new physicians needing practice sites. Several states, such as New York and Oklahoma, have attacked the problem of distribution by sponsoring a variety of programs with different strategies. For example, the Oklahoma Physician Manpower Commission has oversight responsibility for a range of programs, including two service-contingent loan programs for physicians, one service-contingent loan program for nurses, a primary care residency program with a geographical focus, and a placement service that matches physicians with communities in need. Thus, a student participating in the service-contingent loan program could get a residency position as well as placement assistance through the state.

The program managers recognize that the impact of a single strategy is necessarily limited and thus a number of them suggested a more multi-faceted approach. A multi-faceted approach is being implemented in a number of states, most notably North Carolina and Oklahoma. These approaches combine several of the following separate strategies:

- Active recruitment and selection of students who are most likely to prefer primary care specialties in underserved areas.
- Educational experiences, such as extended community preceptorships and primary care residencies, that will reinforce their commitment to their previous interests.
- Financial support for those students needing assistance, combined with a service commitment and high buyout penalties.
- Preparation of the community residents to receive "their" student, as well as development of the practice site. This takes

the form of community financial participation in supporting a particular medical student, such as the Worcester County, Maryland, Medical Scholarship Program, or in the capital needed to start a new practice, such as the North Carolina Office of Rural Health Program.

- Support once a physician begins to practice in a shortage area, through such means as the development of professional networks, continuing medical education, high-technology communications links, sharing on-call duty, and other methods to end professional isolation in underserved areas. These physicians can also serve as preceptors for the next generation of students, thus ameliorating their own isolation while providing the examples for future physicians.
- As necessary, continued financial support in economically depressed rural and inner city areas. This support could be directly to the physicians, such as the Central Nevada Rural Health Consortium, to institutions using their services, such as the Arkansas Rural Medical Clinic Revolving Loan Fund, or to community groups, such as the Oregon Office of Rural Health's grants to communities.

As discussed earlier in this chapter, each of these approaches has been undertaken separately. What is generally lacking, however, is an approach that blends the strategies already present into a continuum of methods seeking to influence specialty and location choices from the period prior to admission to medical school to the ongoing practice of a mature physician. This continuum can provide the necessary reinforcement to physicians' specialty and location decisions at multiple points in their careers: before medical school, during medical school and residency, in the early years of practice, and as their practices mature.

The integrated multi-faceted strategy need not be concentrated in a single program in each state, but rather might be the responsibility of multiple programs that have agreed to work together, with the role of each in manpower distribution clearly articulated and coordinated with each of the other programs. The continued existence of multiple programs may well broaden the constituencies (and thus the resources) supporting the strategy as a whole. On the other hand, fragmentation of purpose and even targeted communities and students remains a constant danger where multiple programs responsible to multiple sponsors exist. A number of program administrators expressed interest in pursuing a multi-faceted approach, recognizing that such integration is difficult to implement. In the states' experience to date, integration of programs appears to be most successful where there is a program manager or outside political figure, such as a governor or major legislator, pushing for and encouraging greater cooperation among programs.

2. Service-contingent programs are an effective but expensive method to place health professionals; preceptorships and other curriculum changes are significantly less expensive but may not be as effective.

Service-contingent programs with high buyout penalties appear to be an effective method of placing health professionals in shortage areas. Unfortunately, they are also an expensive method of doing so, since the cost per physician generally includes full tuition for four years of medical school plus accrued interest during medical school and residency.

The high cost of the service-contingent programs has renewed interest in less expensive methods of affecting students' career choices, such as preceptorships. These programs are often financed through tuition and general medical education subsidies. Program costs are minimal because, while students may receive a small stipend, preceptors usually participate without compensation. These less-expensive programs have great appeal, but unfortunately little is known about their effectiveness in the eventual placement of physicians in shortage areas.

Program managers and policymakers should rigorously evaluate the relative benefits and costs of the varied approaches. While service-contingent programs appear to be more effective on a person-by-person basis, more people can be involved in other programs for each dollar spent. It is not clear from the available information which type of program is most efficient in encouraging placement of physicians in shortage areas, nor the precise impact of types of programs operating together.

3. Service-contingent programs with high penalties for buyout are an effective means of temporarily recruiting health professionals to shortage areas. However, more permanent retention of physicians in these areas may require additional commitment of programs and resources.

Service-contingent aid programs continue to constitute the largest single group of state programs. Efforts to improve the effectiveness of this approach have focused on raising the costs of buyout. Most service-contingent programs have opted to impose stricter penalties for buying out of the program in an effort to maintain the financial aid component while increasing the proportion of participants fulfilling their service obligations in underserved areas. For example, following the NHSC lead, the Georgia State Medical Education Board Program changed from no penalty for non-fulfillment of service to a penalty for three times the principal plus interest. As a result, the proportion of students fulfilling their service obligations increased from 45 percent in 1981 to 70 percent in 1986.

States have generally found that high buyout penalties induce more students to serve in shortage areas. Measured against the goals of the proportion of physicians accepting service commitments, the success of these programs can be high. Some states have concluded, however, that initial placement is only one element of the program's goals. If physicians move at the end of their service commitment, which is a maximum of four years, then they need to be replaced, often with another physician who has also received substantial financial support. Retaining former obligees in shortage areas once their commitment has expired has become an important independent program goal.

Some states, recognizing that the increased supply of physicians has eased earlier recruitment problems, have shifted emphasis to efforts to develop the health services infrastructure in underserved areas. In the words of one administrator, "The pool [of physicians] is sufficient, but there is a need for site development." For example, the California Health Service Corps was phased out, but the Rural Health Division continues to administer a program of health services development grants and to provide technical assistance and coordination to rural health programs.

Many program administrators believe that financial and technical assistance to health care delivery systems for underserved and vulnerable populations, such as migrant farmworkers, is essential to retain providers and continuity of services. For example, in New York, the Bureau of Health Resources Development, which assists in the placement of those obligated under the state's service-contingent aid programs, has been working closely with local health departments and planning agencies to assess primary care needs on a small area basis and to develop approaches to coordinate and link the various program elements in both state and federal initiatives which can address the issue of improving the delivery of primary care services in underserved areas.

Many state policymakers and program managers recognize that some areas in their states lack the economic base to support financially viable physicians' practices. They are searching for the most cost-effective methods to retain physicians in such areas.

As discussed above, states' experiences can give guidance to policymakers in the design of new programs and the retention or modification of existing programs. The methods the states use to target their geographic areas of greatest need may also prove instructive; these methods are discussed in the following chapter.

CHAPTER THREE STATE SERVICE AND SHORTAGE AREA CRITERIA

This chapter describes the criteria employed by the programs and their relationship to the federal Health Manpower Shortage Area (HMSA) process. Of particular interest are the criteria that states use in determining placement of health professionals, particularly for decentralized training, AHECs, service-contingent programs, and grants for practice start-ups.

A. DESCRIPTIONS OF STATE SERVICE AND SHORTAGE AREA CRITERIA

Of the 113 Compendium programs, 61 (54 percent) have some type of shortage area criteria. As Table 5 shows, about a third of programs and states use the federal HMSA criteria or slight modifications of them. Only two programs and states use the HMSA and/or MUA criteria. The remaining programs place personnel in areas according to population-to-physician ratios, rural community size, placement anywhere in the state or on a case-by-case basis. Four states have different shortage area criteria.

When the type of program was compared to the form of area shortage criteria, no pattern emerged. For example, service-contingent programs rely on various forms of shortage area criteria to place health professionals. These programs account for 35 (57 percent) of the programs using placement criteria. Service-contingent programs are the only programs to place health professionals anywhere in the state, by community size, or by population-to-physician ratios.

Table 5
SHORTAGE AREA CRITERIA

Criteria	Programs	*States
HMSA	16	14
HMSA and/or MUA	2	2
Modified HMSA	5	4
Population:physician ratios	3	3
Community size	8	8
Anywhere in state	10	8
State criteria	8	4
Other	9	8
TOTAL	61	51

* States do not total to 50 because multiple programs in the state use the same criteria. Eight states with programs have no criteria.

1. Health Manpower Shortage Areas (HMSA)

As Table 5 shows, states rely heavily on the federal HMSA and Medically Underserved Area (MUA) designation processes for their own programs, usually finding HMSA the more useful process. Sixteen programs in 14 states (Arizona, Kentucky, Massachusetts, Maine, Nebraska, New Mexico, North Carolina, North Dakota, Oklahoma, Pennsylvania, South Carolina, Tennessee, Virginia, and West Virginia) use HMSA alone. Two programs in two states (Arkansas and Nevada) use HMSA or MUA. No programs use MUA alone. A HMSA is defined as "an area in an urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services) which the Secretary determines has a health manpower shortage, a population group which the Secretary determines has such a shortage, or public or nonprofit private medical facility or other public facility which the Secretary determines has such a shortage."

To be designated as a primary care HMSA, a geographic area must satisfy three criteria:

- The area must be a rational service area for the delivery of primary health care.
- It must have a population-to-primary-care-physician ratio of at least 3,500:1, but not less than 3,000:1 and demonstrate unusually high needs for primary medical services or insufficient capacity of existing primary care providers.
- Primary care manpower in contiguous areas must be demonstrated to be overutilized, excessively distant or inaccessible to the population of the area under consideration.

Where an area's population-to-physician ratio falls between the critical ratio of 3,500:1 and 3,000:1, a demonstration of unusually high need or insufficient capacity requires that the area meet at least one need criterion or at least two insufficient capacity criteria. The need criteria are: high birth rate, high infant mortality rate, and a high percentage of population in poverty. The insufficient capacity criteria include high physician visit rates, long waits for appointments, excessive use of emergency facilities for routine care, rate of physicians not accepting new patients, and a low annual office visit rate.

Those states using HMSA for their own programs report doing so for three reasons:

- Some say that the HMSA methodology, while not perfect, is sound and useful for their purposes.
- Others indicate preference for having federal program officials expend the necessary resources for undertaking the process, and, equally importantly, absorb the dissatisfaction from some professional societies or unsuccessful applicant communities.
- Finally, at least a few states express preference for developing their own designation process, but lack the necessary staff. For

example, Michigan had begun developing a shortage area methodology, but budget constraints led to the continued use of the federal HMSA.

2. HMSA Modifications

Five additional programs in four states essentially use the HMSA designations to place health professionals, modifying the process only slightly to suit their own purposes. These programs are in Maryland, Maine, New Mexico, and North Carolina.

These states accept the HMSA designation of geographic shortage areas. The four states then add their state and local health, mental health, and corrections institutions to a list of acceptable practice sites. Unlike the federal designation process, there are no formal state mechanisms for declaring particular institutions to be lacking sufficient personnel. States by and large have not submitted requests to have health institutions designated as HMSAs, since they have low expectations of receiving federal National Health Service Corps assignees for these institutions. In addition to practice in a geographic HMSA, Maine also permits service in particular specialties or to population groups which are determined by the State Department of Health to be underserved on the basis of physician manpower.

3. Population-to-Physician Ratios

Three states use population-to-physician ratios for county-wide designations. These states and their ratios are Kansas (3,000:1), Kentucky (4,500:1), and South Carolina (2,000:1). A report on the Kansas shortage designation approach is available from the Department of Health and Environment.¹¹

4. Community Size

Eight programs in eight states define maximum community size as the criterion for identifying placement areas, focusing their placements on rural areas. Five of these states have over one-third of their populations in non-metropolitan areas. The programs assume that small communities lack necessary medical services.

The programs with placements according to community size are Alabama (5,000 population maximum), Arkansas (8,000), Georgia (15,000), Illinois (35,000), Missouri (6,500), Mississippi (10,000), Oklahoma (7,500), and Texas (30,000). Illinois also requires that students enter primary care specialties if they are to qualify for service payback. A particularly interesting example is Alabama, where the Medical Student Loan Program completely forgives loans for 4 years' service in a community with less than 5,000 population, but only 50 percent of the loan for 5 years' service in a community of 15,000 to 100,000 population. Alabama and Mississippi also forgive the loans in return for 4 years' practice in public health or as a physician in a state-approved institution.

¹¹ Kansas Department of Health and Environment. "The 1985 Kansas Medically Underserved Areas Report," December 31, 1985.

5. Anywhere in the State

Ten programs allow participants to fulfill their requirements anywhere in the state. These programs are in Alaska, Arizona, Kansas, Massachusetts, Maryland, Washington, West Virginia, and Wisconsin. Kansas permits practice anywhere in the state, but it must be in a primary care specialty. The Arizona/WICHE Professional Student Exchange Program also permits students to complete their obligation at an accelerated rate if they practice in an area on a case-by-case basis defined as underserved. This results in credit for one year of service for each six months of practice. Maryland, for example, permits service anywhere in the state except Montgomery County, an affluent suburb of Washington, D.C.

6. State Criteria

Four states have developed detailed shortage area designation processes which often parallel the HMSA designation methodology but differ in significant details. These states are California, Illinois, New York, and Oregon. Published material on the shortage area designation methodologies is available from California, New York, and Oregon.¹²

a. California

To be designated as a primary care physician shortage area by the California Health Manpower Policy Commission, a geographic area must satisfy three criteria:

- It must be a medical service study area for the delivery of health care. These areas are counties or census tracts, grouped to reflect community patterns for obtaining medical care.
- It must have a population-to-primary-care-physician ratio greater than 1,967:1.
- It can have a population-to-primary-care-physician ratio greater than 1,855:1 with one of the following conditions: population

¹² California Health and Welfare Agency. "1983-1984 California Health Manpower Plan, Supplement 1: Medically Underserved Areas in California." August 1985.

New York State Health Planning Commission. "Primary Care Profile," January 1984.

New York State Department of Health. "Planning Guidance for Health Systems Agencies for the Preparation of Regional Plans for Primary Care and Preventive Services," September 1985.

Oregon State Health Planning and Development Agency. "Primary Health Care in Rural Oregon," September 30, 1985.

over age 65 greater than 22.5 percent, population age 4 or under greater than 9.5 percent, and a population below the poverty line greater than 20 percent.

California also has three criteria for designating an area in need of primary care medical personnel fluent in a language other than English: (1) more than 25 percent of the population do not speak English; (2) the non-English speakers total at least 2,500 persons; and (3) the ratio of non-English speakers to each primary care physician fluent in their language is more than 2,248:1.

The California Health Manpower Policy Commission has identified a number of issues that affect its ability to set priorities among areas. One issue is data availability. The Commission uses the American Medical Association (AMA) Directory information, augmented by telephone directory listings and telephone interviews of physicians' offices to verify location and ascertain hours in practice. Data are continually being refined, but they are never completely current. A second issue is the instability of designations. A single physician entering or leaving practice can affect designation, particularly in rural areas. After a formal announcement of impending designation, areas are maintained on a list for one year while the Commission determines whether the conditions disqualifying the area are likely to be permanent.

b. Illinois

The Illinois Department of Public Health has responsibility for designating physician shortage areas, which are used to place physicians fulfilling their service obligations under the Family Practice Residency Act Scholarship Program.

The Department maintains its own database by county, which contains the following elements: physician office locations (from the Yellow Pages), physician practice data (number of physicians by specialty reported by the AMA), 1980 population, and travel distances.

Criteria for the designation of physician shortage areas were developed specifically for Illinois. A community/area will be designated as a primary care physician shortage area if it meets one of the following criteria:

- A county or subcounty area with a population-to-primary-care-physician ratio of at least 3,000 to 1.
- A town with a population capable of supporting a physician, that has no physician or no physician services within a ten-mile travel distance.
- A service area with no physicians specializing in pediatrics, regardless of population-to-primary-care-physician ratio.

c. New York

New York's Regents Shortage Area designation has been a very simple physician-to-population ratio until recently when the state health planning commission and the health department developed a new approach to designate Primary Care Priority Areas as a tool to support a more aggressive and coordinated practitioner placement approach for both NHSC and state-obligated health professionals.

In effect, the process reverses the HMSA designation priorities by first considering need, measured on two dimensions: health status (infant mortality rates, low birthweights, and mortality rates for nonelderly adults excluding trauma deaths); and sociodemographic factors (poverty rate and percent of the population over 65 and 75). Other local factors, such as physicians' refusal to treat certain types of patients, unemployment rates, and other factors affecting adequacy, accessibility and appropriateness of care, may be added. Physician resources are calculated by weighting available supply by age, specialty, and practitioner density factors then converted to an annualized available visit estimate. This is matched to an estimate of demand generated from extrapolation of national Health Interview Survey visit estimates corrected for local area demographic characteristics; the resulting Primary Care Service Index represents a measure of satisfied demand. The New York approach is unique in taking into account the availability of institutional providers of primary care as well as of federal and state funds for primary care and preventive services.

d. Oregon

The Oregon designation process is similar to New York's, in that it first examines health status. The process first calculates "need" for primary care by county, using zip code data, including health status factors (age-adjusted death rate, years-of-life lost index, average infant mortality, percent births with inadequate prenatal care) and socio-economic factors (poverty, unemployment, education, and migrant farmworkers). Each health status and socio-economic factor is rated on a scale of 1 to 5, with 5 being "poor." This first step identifies counties with problems. Next, resources are investigated, including: supply and demand for physicians, rural clinics, funding, emergency care, and hospital resources. These variables are also scored. Finally, the program examines geographic barriers, funding barriers, and economic and cultural barriers to access. These scores result in a "problem matrix" which lists problems and resources. This inventory is used to formulate primary care plans for rural areas of the state.

e. Comparisons with HMSA

Table 6 compares these four states' methodologies to the federal HMSA process. It compares methodologies across four criteria: definition of a service area, order of factors in designating underserved areas, physician-to-population ratios, and special provisions included in the methodologies. California and New York have developed service area definitions which rely on similar criteria as HMSA, but may result in designations that differ from actual HMSA designations. The Medical Service Study Area in California and the Primary Care Priority Area in New York are counties or census tracts grouped to reflect community patterns for obtaining medical care.

Table 6
COMPARISON OF FOUR STATES' CRITERIA TO HMSA

	HMSA	STATE			
		CALIFORNIA	ILLINOIS	NEW YORK	OREGON
SERVICE AREA	"Rational"	Medical service Study area	County, town, or area	Primary care priority areas	County
ORDER OF FACTORS	Physician ratios High need Insufficient capacity	Physician ratios High need	Physician ratios No pediatrician	Health status & Socio-economic factors Health manpower	Health status Socio-economic Resources Geographic
POPULATION-TO-PHYSICIAN RATIOS	3,500:1 3,500-3,000:1 In high need	1,967:1 1,855-1,967:1 In high need	3,000:1	None	2,500:1
SPECIAL PROVISIONS	Special populations Public institutions	Language desig- nations Keep area on roll one year	10-mile travel distance	Special popu- lations	None specified

California and Illinois parallel the HMSA process and place first priority on population-to-physician ratios in designating underserved areas. New York and Oregon place first priority on health status and socioeconomic factors and, in effect, reverse the order of factors of the HMSA criteria.

Population-to-physician ratios vary across state methodologies. New York does not rely on a population-to-physician ratio in designating underserved areas, while California (1967:1), Illinois (3000:1), and Oregon (2500:1) are all below the HMSA population-to-physician ratio of 3500:1.

Finally, all state methodologies with the exception of Oregon include special provisions for determining underservice. New York, similar to HMSA, allows special population group designations such as Native Americans. Illinois uses a travel distance to a provider of more than 10 miles as an indication of underservice compared to the HMSA travel distance that corresponds to 30 minutes travel time. California includes language designations for areas that are largely non-English speaking.

7. Other

Eight other programs in seven states use area selection criteria that do not fit neatly into the above categories. In seven programs in six states (Kansas, Kentucky, Minnesota, New Mexico, Oregon and Virginia), placements are made on a case-by-case basis without published criteria. For example, Kansas, Minnesota, and New Mexico use "rural" to qualify locations, but they do not specify that these be non-Metropolitan Statistical Areas or other formal measures of "rural." The Kentucky Primary Care Residency Program permits placement in counties other than those in which medical schools are located, i.e., in non-metropolitan areas. Finally, Worcester County in Maryland sponsors medical students in return for promise to practice in that underserved county, which has also been designated as an HMSA.

B. CONCLUSION

Programs primarily rely on HMSA criteria in placing health professionals in shortage areas. Those that do not rely on HMSA criteria generally apply more lenient criteria to placing health professionals, such as anywhere in the state or in a community below a specified size. These more lenient provisions enable programs to place many more health professionals throughout the state than the use of the HMSA process alone would have allowed. Use of HMSA criteria by a large number of programs demonstrates the importance of this designation process to the administration of state programs. With the exception of eight programs in four states which employ alternative criteria, states are not duplicating or substituting for the HMSA process.

Over the past several years, modifications to the HMSA designation process have been considered. Based on this study's review of program area placement criteria, the widespread use of the HMSA methodology indicates that program administrators believe HMSA designations are adequate for placing health professionals in communities in need. Changes do not appear to be needed in the definition of a rational service area or the population-to-physician ratios.

However, policymakers may want to reconsider the priority placed on elements in the HMSA criteria. New York and Oregon have developed physician placement criteria that place a higher priority on health status measures than health resource availability in measuring areas of underservice. These state officials believe that health status measures provide a more accurate indicator of lack of access to care than physician-to-population ratios. The New York and Oregon approaches to measuring underservice should be examined before considering changing the HMSA criteria.

CHAPTER FOUR

PROGRAM DESCRIPTIONS

This chapter presents individual program descriptions, organized by state. A state-specific matrix precedes program descriptions for each state. Each program has been classified by type of approach (experiences-during education, financial incentives, aid in practice) and by specific strategy within each state section.

A. GLOSSARY

Each program summary contains a series of descriptors, which are defined below in the order in which they appear.

1. Administrative Locus

The state or private organization responsible for oversight of the program.

2. Administrator

Individual designated by Compendium respondent as responsible for program operation.

3. Type of Incentive

- **EXPERIENCES DURING EDUCATION:** These programs attempt to influence specialty choice or practice location during the educational process. Four major types of programs were identified:
 - Primary Care Residencies for institutions to establish programs or support individuals in existing programs.
 - Seat Purchase for medical school positions, usually to ensure that students from states which do not have public medical schools can attend medical school.
 - Preceptorships for undergraduate medical students which expose students to clinical practice in underserved or rural areas.
 - Other curriculum innovations, such as an educational program for high school students from underserved areas to enable them to attend medical school and an accelerated college and medical school program for students from rural areas.
- **FINANCIAL INCENTIVES:** These programs give financial aid, often in return for a commitment to practice in a particular specialty area or location. Three major types of programs were identified:
 - Service-contingent loans and scholarships: financial assistance which will be forgiven for practicing specific specialties or locations upon completion of medical school.

- Other Loans for medical education. These low interest loans are intended to assist students in attending medical school.
- Other Scholarships for medical education.
- **AID IN PRACTICE:** These programs attempt to influence the location of practicing providers. Four major types of programs were identified:
 - Placement services which match communities in need with physicians seeking practice opportunities.
 - Loans: Low-interest loans to providers for use in establishing practices in specific locations.
 - Guaranteed income to providers who agree to practice in a certain location.
 - AHEC sites which provide continuing education, placement services, and attempt to minimize provider isolation in remote areas. AHECs also affect the educational experience by providing support to residency programs and sponsoring training in decentralized sites.

4. Narrative Description

A brief overview of program design and activities, highlighting major achievements and obstacles to implementation.

5. Goals

Outcomes that program activities are designed to achieve.

6. Participating Institutions

Organizations supporting and/or involved in program activities.

7. Eligibility

Requirements that must be satisfied by potential program participants.

8. Area Selection Criteria

Criteria used by the program to determine placement sites for program participants.

9. Conditions

Description of financial aid awards.

- MINIMUM ANNUAL AWARD: Minimum amount of financial aid available to individual participants annually.
- MAXIMUM ANNUAL AWARD: Maximum amount of financial aid available to individual participants annually.
- AVERAGE ANNUAL AWARD: Average amount of financial aid available to individual participants annually.
- OVERALL MAXIMUM AWARD: Maximum amount of financial aid available to individual participants during participation in the program.
- MAXIMUM YEARS OF AID: Maximum years for which an individual may participate in the program.

10. Service Obligation

For service-contingent programs, the number of years and site at which participants are required to serve in return for financial aid.

11. Buyout Provisions

For service-contingent programs, the conditions under which an individual participant may opt not to fulfill his/her service obligation.

12. Standards for Program Evaluation

Standards specified by program administrators as those used to evaluate program effectiveness.

13. Outcome

Program outcomes as reported by program administrators.

14. Annual Funding Levels

Funding levels for program fiscal years 1983-1985.

15. Current Source of Funding

Source of program funding: percent by federal, state, local, and private sources.

16. Participant Profile

Number of participants, including total number, as well as the proportion who are: state residents, male, female, black, Hispanic, and other minorities.

Items left blank in the individual program descriptions indicate either that the information is not applicable to or is unavailable from the program.

B. PROGRAM DESCRIPTIONS

The remainder of this chapter contains the summaries of the 113 programs.

ALABAMA
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
				X	X					

X = Presence of program.
+ = Program added since 1981.
- = Program discontinued since 1981.

- 51 -

Alabama

Alabama

PROGRAM (Date Initiated): Alabama Medical Student Loan Program (1965)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Frieda Baldwin, Accountant
Address: Board of Medical Scholarship Awards
Box 443, University Station
Birmingham, AL 35294
Telephone: 205-934-4384

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES: Service-contingent Loans and Scholarships**

NARRATIVE DESCRIPTION:

The Alabama Board of Medical Scholarship Awards disburses state-funded loans to Alabama residents attending medical school. There is no commitment to practice in a shortage area upon receipt of the loan, however, loans may be forgiven for service in one of the following ways:

- Four years' practice in a community of less than 5,000 population.
- Five years' practice in a community of 5,000-15,000 population.
- Five years' practice in a community of 15,000-100,000 population while repaying 50% of the loan.
- Four years' practice in public health or as a physician in a state-approved institution.

GOALS:

1. Attract physicians to underserved rural areas.
2. Retain state medical graduates within the state.

PARTICIPATING INSTITUTIONS: Medical school

ELIGIBILITY: State resident, financial need

AREA SELECTION CRITERIA: Community size: Four years' practice in a community of less than 5,000 population; five years' practice in a community of 5,000-15,000 population; five years' practice in a community of 15,000-100,000 population while repaying 50% of the loan; four years' practice in public health or as a physician in a state approved institution.

Alabama

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ No Minimum	\$3,000	\$3,000	\$12,000	4

SERVICE OBLIGATION

One year for each year
aid in an area approved
by the Board of Medical
Scholarship Awards.

BUYOUT PROVISIONS

Repayment over 8 years
at a 6% interest rate
with a one-year grace
period.

STANDARDS FOR
PROGRAM EVALUATION:

OUTCOME:

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$</u>	<u>\$</u>	<u>\$</u>

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 100%
LOCAL: 0%
PRIVATE: 0%
TOTAL: 100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	<u></u>	<u></u>	<u></u>
% In-State Residents	<u></u>	<u></u>	<u></u>
% Training/ Practicing in Rural Setting	<u></u>	<u></u>	<u></u>
% Rural Origin	<u></u>	<u></u>	<u></u>
% Male/Female	<u></u>	<u></u>	<u></u>
% Minority	<u></u>	<u></u>	<u></u>

ALASKA
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
	X			X						

X = Presence of program.
+ = Program added since 1981.
- = Program discontinued since 1981.

- 1

- 54 -

Alaska

PROGRAM (Date Initiated): Alaska Student Loan Program (1971)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:
 Director/Contact Person: Kerry Romesburg, M.D., Executive Director
 Address: Alaska Commission on Post-Secondary
 Education
 P.O. Box FP
 Juneau, AK 99811
 Telephone: 907-465-2854

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES: Service-contingent Loans and Scholarships**

NARRATIVE DESCRIPTION:

The state-funded Alaska Student Loan Program provides financial support to Alaska residents seeking post secondary education outside the state. A provision of the loan allows for cancellation of half the debt if the recipient returns to Alaska to practice for six years.

GOALS:

1. Reduce financial barriers to medical training for state residents.
2. Retain state medical graduates within the state.

PARTICIPATING INSTITUTIONS: Medical school.

ELIGIBILITY: State resident.

AREA SELECTION CRITERIA: Anywhere in the state.

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ No minimum	\$7,000	\$6,200	\$28,000	4

SERVICE OBLIGATION

BUYOUT PROVISIONS

None, but 50% of the loan is forgiven if student returns to Alaska and practices for 6 years.

Alaska

STANDARDS FOR
PROGRAM EVALUATION: Proportion of students who return to Alaska.

OUTCOME: Approximately 18% return to Alaska; however, among students with these loans who are also in the WAMI program (see next Narrative Description), 48% return to Alaska.

ANNUAL FUNDING LEVELS:	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	\$74,000,000	\$77,000,000	\$79,000,000

CURRENT SOURCE OF FUNDING: (PERCENT)	FEDERAL: 0%
	STATE: 100%
	LOCAL: 0%
	PRIVATE: 0%
	TOTAL: 100%

PARTICIPANT PROFILE:	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	_____	_____	_____
% In-State Residents	_____	_____	_____
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

Alaska

PROGRAM (Date Initiated): Washington, Alaska, Montana, Idaho (WAMI)
Regional Program (1971)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Sven Ebbesson
Address: University of Alaska
Arctic Health Research Building Room 103
Fairbanks, AK 99701
Telephone: 907-474-7731

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Seat Purchase

NARRATIVE DESCRIPTION:

WAMI is a program in Washington, Alaska, Montana and Idaho whose purpose is to guarantee access to medical school to qualified students from the four states and is designed to expose students to medical practice outside of metropolitan areas. Students from the participating states enroll at the University of Washington School of Medicine, the only public medical school in the four states, but take basic science courses on their "home" campuses (e.g., University of Alaska) for the first year. After the first year, they move to the Seattle Campus. In the third and fourth years, students may elect to take six weeks of primary care clinical training with community physicians in seven different locations within the four state area. Physicians providing clerkship training are appointed to the School of Medicine faculty, allowing them continuing educational opportunities there.

The participating states bear their respective shares of the program costs and in return benefit from the increased availability of physicians without the cost of constructing medical schools. The states also have a similar arrangement with the University of Washington for physician's assistants.

GOALS:

1. Provide access to medical school for qualified applicants.
2. Attract physicians to primary care practice in non-metropolitan areas.
3. Increase the number of practicing physicians in states without medical schools.

PARTICIPATING INSTITUTIONS: Medical schools, colleges, hospitals, ambulatory care facilities, group practices, private practices.

CLINICAL SPECIALTIES: Internal medicine, ob/gyn, family practice, pediatrics

Alaska

AREA SELECTION CRITERIA:

STANDARDS FOR
PROGRAM EVALUATION: Number of state residents in medical school, number of
physicians who return to practice in Alaska.

OUTCOME: 44% of participants return to practice in Alaska.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$1,300,000	\$1,500,000	\$1,600,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	40	43	48
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female	55/45	58/42	58/42
% Minority			

ARIZONA
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
				X						

X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

Arizona

PROGRAM (Date Initiated): Arizona/WICHE Professional Student Exchange Program (1953)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Dr. Odus Elliott, WICHE Cert. Officer
Address: Arizona Board of Regents
1501 W. Jefferson
Phoenix, AZ 85007
Telephone: 602-255-4082

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES:** Service-contingent Loans and Scholarships

NARRATIVE DESCRIPTION:

Sponsored by the Western Interstate Commission on Higher Education (WICHE) and administered by the Arizona Board of Regents, this state-funded program allows Arizona students to enroll in five health professions programs not available in Arizona. These programs include dentistry, veterinary medicine, optometry, osteopathy and occupational therapy. Through the exchange, the student receives preference in admission and pays only the resident tuition fee at a public institution or approximately one-third of the standard tuition at a private school. The State of Arizona pays a support fee to the school receiving the student to help cover the cost of education. Students incur an obligation to either practice in Arizona for one year for each year of their participation or repay the state one-half of the support fees paid by the state to the medical college on their behalf. Students may complete their obligation at an accelerated rate if they practice in a defined underserved area. This results in credit for one year of service for each six months of practice.

As of 1982, medical students were no longer eligible to participate in the program, due to an improvement in physician manpower.

- GOALS:
1. Provide access for Arizona residents to receive medical training.
 2. Reduce financial barriers to medical training for state residents.
 3. Achieve a balance of physician supply with projected need or demand for medical care.

PARTICIPATING INSTITUTIONS: Western Interstate Commission for Higher Education, other educational institutions.

ELIGIBILITY: State resident.

Arizona

AREA SELECTION CRITERIA: Anywhere in the state.

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ No minimum	\$14,400	\$14,400	\$57,600	4
<u>SERVICE OBLIGATION</u>		<u>BUYOUT PROVISIONS</u>		
One year of practice in the state for each year of support. Those who practice in an underserved area receive one year of credit for each 6 months of practice.		Repay 50% of support plus 12% interest accruing from the date of graduation over a 10-year time period.		

STANDARDS FOR
PROGRAM EVALUATION:

OUTCOME:

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$2,028,200	\$1,823,350	\$1,835,300

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	178	165	158
% In-State Residents	178	165	158
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

Arizona

PROGRAM (Date Initiated): Arizona Medical Student Loan Program (1977)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Andrew Goldner, M.D.
Associate Dean of Student Affairs
Address: College of Medicine - Room 2208
Arizona Health Sciences Center
1501 N. Campbell Street
Tuscon, AZ 85724
Telephone: 602-626-6216

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES:** Service-contingent Loans and Scholarships

NARRATIVE DESCRIPTION:

Loans for educational support are granted to medical students who in return agree to practice for a specified period of time in a rural HMSA in Arizona. The program is intended to fill health manpower needs in the state of Arizona.

GOALS:

1. Increase access to medical care in underserved urban and rural areas.
2. Retain medical graduates within the state.
3. Reduce financial barriers to medical training for state residents.

PARTICIPATING INSTITUTIONS: Medical school

ELIGIBILITY: State resident, financial need, acceptance into University of Arizona Medical School.

AREA SELECTION CRITERIA: HMSA (rural).

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ No minimum	\$6,000	\$6,000	\$24,000	4

SERVICE OBLIGATION

One year per year of aid;
minimum service requirement
of two years.

BUYOUT PROVISIONS

Principal + \$5,000 pay-
able within one year at
7% interest rate.

Arizona

STANDARDS FOR
PROGRAM EVALUATION: Number of physicians who complete service requirement.

OUTCOME: First placements in 1985. One bought out, 10 are serving.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$118,000	\$120,000	\$120,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	29	26	18
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting			
% Rural Origin	24	27	17
% Male/Female	62/38	62/38	72/28
% Minority	41	50	56

ARKANSAS
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
				X					X	X

X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

Arkansas

PROGRAM (Date Initiated): Physician Placement Service (1951)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: David Wroten
Professional Relations Coordinator
Address: Arkansas Medical Society
P.O. Box 5776
Little Rock, AR 72215
Telephone: 501-224-8967

TYPE OF INCENTIVE: AID IN PRACTICE: Placement

NARRATIVE DESCRIPTION:

The Physician Placement Service of the Arkansas Medical Society assists communities, physicians, and other individuals in their efforts to recruit physicians into medically underserved areas of the state. The Medical Society maintains lists of physicians seeking practice in Arkansas and communities in need of a physician. This is part of the society's operations pertaining to community and public relations.

GOALS:

1. Attract physicians to underserved urban and rural areas.
2. Achieve a balance of physician supply with projected need or demand for medical care.
3. Retain state medical graduates within the state.

PARTICIPATING INSTITUTIONS: Medical school, hospital, ambulatory care facility.

CLINICAL SPECIALTIES:

AREA SELECTION CRITERIA:

STANDARDS FOR
PROGRAM EVALUATION:

OUTCOME:

ANNUAL FUNDING
LEVELS:

	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	<u>\$</u>	<u>\$</u>	<u>\$</u>

Arkansas

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 0%
LOCAL: 0%
PRIVATE: 100%
TOTAL: 100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	_____	_____	_____
% In-State Residents	_____	_____	_____
% Training/Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

Arkansas

PROGRAM (Date Initiated): The Arkansas Rural Medical Practice Student Loan and Scholarship Program (1940)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: George Warner
Assistant Dean for Administration
Address: University of Arkansas School of Medicine
4301 W. Markham Street
Little Rock, AR 72201
Telephone: 501-661-5353

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES:** Service-contingent Loans and Scholarships

NARRATIVE DESCRIPTION:

This state-funded program provides scholarships for educational support of those Arkansas residents who are undergraduate medical students at the University of Arkansas College of Medicine and who agree to practice in a rural area in Arkansas once their training is complete. Power to designate areas of service as well as to select financially needy scholarship recipients is vested in the Rural Medical Service Student Loan and Scholarship Board. Recipients are required to practice for one year for each year of support with a minimum service commitment of two years.

GOALS:

1. Reduce financial barriers to medical training for state residents.
2. Attract physicians to underserved rural areas.
3. Retain state medical graduates within the state.

PARTICIPATING INSTITUTIONS: Medical school

ELIGIBILITY: State resident, financial need, commitment to practice in medically underserved or shortage area. Commitment to primary care, acceptance at the University of Arkansas College of Medicine.

AREA SELECTION CRITERIA: Community size: fewer than 8,000 population.

Arkansas

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ No minimum	\$8,000	\$8,000	\$32,000	4
<u>SERVICE OBLIGATION</u>		<u>BUYOUT PROVISIONS</u>		
One year for each year of aid with a 2-year minimum.		Principal due immediately with a 10% interest rate retroactive from the award date. There is a maximum of 3 years to repay the loan.		

STANDARDS FOR
PROGRAM EVALUATION: Number of students fulfilling service obligations.

OUTCOME: 1983: 58% fulfilling service obligation
 1984: 53% fulfilling service obligation
 1985: 57% fulfilling service obligation

<u>ANNUAL FUNDING LEVELS:</u>	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	\$400,000	\$400,000	\$400,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

<u>PARTICIPANT PROFILE:</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	60	58	61
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting			
% Rural Origin	66	69	65
% Male/Female	95/5	95/5	95/5
% Minority	3	2	3

Arkansas

PROGRAM (Date Initiated): Rural Medical Clinic Revolving Loan Fund (1980)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Robin Braun
Address: Office of Rural Health
4815 W. Markham Street
Little Rock, AR 72205-3867
Telephone: 501-661-2375

TYPE OF INCENTIVE: AID IN PRACTICE: Loans

NARRATIVE DESCRIPTION:

The Arkansas State Board of Finance administers low interest loans to physicians and loans/grants to communities for the construction, renovation, or equipping of medical clinics. For communities the loan/grant maximum is \$10,000; for physician loans, \$12,000. Loans are repaid at 5 percent over 10 years for communities; 5 percent over 6 years for physicians. Applications are prepared with the assistance of the Office of Rural Health.

GOALS:

1. Assist in the establishment of primary care services in underserved areas.
2. Attract physicians to underserved areas.

PARTICIPATING INSTITUTIONS: Communities, solo practitioners, group practices.

ELIGIBILITY: Primary care physicians in financial need establishing a practice in a federal health manpower shortage area (HMSA).

AREA SELECTION CRITERIA:

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
Physicians:	\$	\$10,561	\$12,000	1
Communities:	\$	\$21,104*	\$10,000	1

* Early on, awards were available much above today's maximum of \$10,000. Average figures based on data since program's inception.

SERVICE OBLIGATION

BUYOUT PROVISIONS

Arkansas

STANDARDS FOR
PROGRAM EVALUATION:

1) Facilities established with state aid experiencing primary care service delivery; 2) retention of physicians.

OUTCOME:	<u>1981</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>	<u>1984.</u>	<u>1985</u>
Total Physician awards	-	-	7	4	3	8
Physicians retained	-	-	6	3	2	6
Physicians died	-	-	0	0	1	0
Total Community awards	11	2	1	2	5	6
Services retained	7	0	1	1	5	6

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$125,000	\$125,000	\$125,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT PROFILE:	<u>1983</u>	<u>1984</u>	<u>1985</u>
Physicians:			
Total, #	4	3	8
% In-State Residents			
% Training/Practicing in Rural Setting*	100	100	88
% Rural Origin*			
% Male/Female	100/0	67/33	88/12
% Minority	25	0	50

* Rural = 10,000 or fewer inhabitants

Communities:	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total	2	5	6
Population <500	2	-	2
Population 500-1,000	-	1	2
Population 1,000-2,000	-	3	2
Population 2,000-5,000	-	1	-

Arkansas

PROGRAM (Date Initiated): University of Arkansas for Medical Sciences Area Health Education Centers Program (AHEC) (1973)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Dr. Charles Cranford, Executive Director
Address: Area Health Education Centers Program
University of Arkansas
4301 Markham Street
Little Rock, AR 72205
Telephone: 501-661-5260

TYPE OF INCENTIVE: AID IN PRACTICE: AHECs

NARRATIVE DESCRIPTION:

The state-funded AHEC program is a system of regionally located educational centers throughout the state, utilizing selected private practitioners and full time University of Arkansas Medical School (UAMS) instructors as faculty and affiliated hospitals and private clinics in six communities as both clinical means and the opportunity for expansion and enhancement of the various clinical education and training programs of the UAMS. The program contributes significantly to the objectives of the College of Medicine to train and retain more primary care physicians for practice in Arkansas.

GOALS:

1. Increase the number of physicians in primary care and/or family practice.
2. Retain state medical graduates within the state.
3. Increase access to medical care in underserved rural areas.

PARTICIPATING INSTITUTIONS: Medical schools, graduate medical training programs, colleges, hospitals, ambulatory care facilities, group practices, private practices.

CLINICAL SPECIALTIES: General practice, internal medicine, family practice, pediatrics.

AREA SELECTION CRITERIA: HMSA and/or MUA.

STANDARDS FOR
PROGRAM EVALUATION:

OUTCOME:

Arkansas

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$</u>	<u>\$</u>	<u>\$</u>

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 100%
LOCAL: 0%
PRIVATE: 0%
TOTAL: 100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #			
% In-State Residents			
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

CALIFORNIA
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
X			-	-					X	

X = Presence of program.
+ = Program added since 1981.
- = Program discontinued since 1981.

California

PROGRAM (Date Initiated): California Family Physician Training Program
(1973)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: William H. Burnette, Program Administrator
Address: Division of Health Professions Development
Office of Statewide Health Planning and
Development

1600 Ninth Street, Fourth Floor
Sacramento, CA 95814

Telephone: 916-322-5566

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Primary Care Residencies

NARRATIVE DESCRIPTION:

Through a program of competitive contracts, the Division of Health Professions Development subsidizes family practice residency programs and training programs for nurse practitioners and physician's assistants. Currently, 23 residency programs and 6 programs training mid-level practitioners are being funded. Major emphases of the program are on decentralization of family practice residencies away from university medical centers to community hospitals and clinics and on team training of physicians and primary care associates (NPs and PAs). The contracts require comprehensive educational components that will prepare the trainees for practice among underserved populations.

GOALS:

1. Attract family practice physicians to underserved urban and rural areas.
2. Strengthen family practice departments in state medical schools.
3. Promote team training of physicians, physician assistants, and nurse practitioners.

PARTICIPATING INSTITUTIONS: Medical schools, graduate medical education programs, colleges and universities, hospitals, ambulatory care facilities, private practice.

CLINICAL SPECIALTIES: Family practice.

AREA SELECTION CRITERIA: State Criteria (See Chapter Three).

STANDARDS FOR

PROGRAM EVALUATION: Annual program review by California Health Manpower
Policy Commission.

OUTCOME: Studies of data on graduate geographic distribution and specialty.

California

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$2,880,000	\$2,880,000	\$2,880,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 100%
LOCAL: 0%
PRIVATE: 0%
TOTAL: 100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #			
% In-State Residents			
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

California

PROGRAM (Date Initiated): Physician Incentive Loan Program (1980)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Rick Wallinder, Analyst
Address: California Board of Medical Quality Assurance
1430 Howe Avenue
Sacramento, CA 95325
Telephone: 916-920-6353

TYPE OF INCENTIVE: AID IN PRACTICE: Loans

NARRATIVE DESCRIPTION:

The Incentive Loan Program was authorized by the California Legislature as a pilot program in 1980 to run through FY 1985-86. It provided up to 10 loans of \$10,000 each to physicians who established practices in state-designated medically underserved areas.

In recent years, the program has been seriously underutilized. In FY 1984, two loans were funded but one was returned because the applicant changed plans; in FY 1985 three loans were approved, but one of the recipients left the area and no longer qualified. The program was given a three-year extension in 1985 with the following key changes: (1) the number of loans was decreased to five; (2) the amount of the loan was increased to \$20,000; (3) information about the program must be disseminated to each newly licensed physician.

GOALS:

1. Attract physicians to underserved urban and rural areas.
2. Increase number of physicians in primary care/family practice.

PARTICIPATING INSTITUTIONS: Private practice.

ELIGIBILITY: California MD license in good standing;
commitment to primary care; commitment to
practice in medically underserved area.

AREA SELECTION CRITERIA: State Criteria (See Chapter Three)

California

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$10,000	\$20,000*	\$10,000	\$20,000*	1**

* after July 1, 1986

** Loan is a one-time grant.

SERVICE OBLIGATION

2 years

BUYOUT PROVISIONS

If practice less than 2 years, $\frac{1}{4}$ of loan amount plus 9% interest, compounded annually, is due within 10 years.

STANDARDS FOR
PROGRAM EVALUATION:

OUTCOME:

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$100,000	\$100,000	\$100,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>TOTALS 1981-1985</u>
Total #			29
% In-State Residents			100
% Training/ Practicing in Rural Setting			76
% Rural Origin			
% Male/Female			72/28
% Minority			60

COLORADO
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
							-			

X = Presence of program.
+ = Program added since 1981.
- = Program discontinued since 1981.

FLORIDA
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
X							X			

X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

Florida

PROGRAM (Date Initiated): Community Hospital Education Program (1971)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Patricia C. Barrett, Ph.D.
Vice Chancellor for Health Affairs
State University System
Address: 107 West Gaines Street
Tallahassee, FL 32301
Telephone: 904-488-5443

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Primary Care Residencies

NARRATIVE DESCRIPTION:

The Community Hospital Education Council's program offers substantial financial support for graduate medical education in the primary care and psychiatric specialties in Florida's hospitals. The program was conceived in response to a perceived need for more primary care physicians and psychiatrists in the state of Florida. It has stimulated a number of training programs in the primary care specialties and has increased the number of physicians who have undergone training in these internships and residencies.

GOALS:

1. Increase the number of physicians in primary care and/or family practice.
2. Achieve a balance of physician supply with projected need or demand for medical care.
3. Attract physicians to underserved urban and rural areas

PARTICIPATING INSTITUTIONS: Graduate medical education programs and hospitals.

CLINICAL SPECIALTIES: Internal medicine, family practice, pediatrics, emergency medicine, psychiatry, and child psychiatry.

AREA SELECTION CRITERIA:

PROGRAM EVALUATION: Statewide gain in the number of physicians.

OUTCOME: 65.5% of participants are now practicing in Florida.

STANDARDS FOR

PROGRAM EVALUATION: Statewide gain in the number of physicians.

Florida

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$4,580,000	\$4,700,300	\$5,291,440

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%*
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

* Participating institutions are required by statute to provide at least 50 percent of program funds from local sources; the annual funding level shown above is the state general revenue appropriation only.

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	293	307	351
% In-State Residents	30	30	30
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

Florida

PROGRAM (Date Initiated): Florida Health Manpower Clearinghouse (1979)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Ken Widergren, Project Director
Address: Florida Health Manpower Clearinghouse
Department of Health and Rehabilitative Services
1317 Winewood Boulevard, Building 1
Tallahassee, FL 32301
Telephone: 904-487-2044

TYPE OF INCENTIVE: AID IN PRACTICE: Placement

NARRATIVE DESCRIPTION:

This program places physicians in underserved areas and approved institutions including correctional facilities, mental institutions, public health facilities, and community health centers. The program (1) identifies and works with underserved communities in need of primary care physicians; (2) identifies in-state and out-of-state physicians desiring Florida practice opportunities; (3) matches communities and physicians on the basis of physician practice preferences and community needs; and (4) facilitates communication between the two parties through exchange of profiles and other promotional material. Technical assistance is also provided to communities in conducting local recruitment programs.

GOALS:

1. Attract physicians to underserved urban and rural areas.
2. Increase access to medical care in underserved urban and rural areas.
3. Provide quality physicians for state institutions.

PARTICIPATING INSTITUTIONS: Community organizations and the University of Florida College of Medicine - Gainesville.

CLINICAL SPECIALTIES: Internal medicine, family practice, pediatrics, ob/gyn.

AREA SELECTION CRITERIA:

**STANDARDS FOR
PROGRAM EVALUATION:** Placements

OUTCOME:

Florida

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$40,000	\$40,000	\$40,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT
PROFILE:*

<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #		
% In-State Residents		
% Training/ Practicing in Rural Setting		
% Rural Origin		
% Male/Female		
% Minority		

* Maintains a list of approximately 300 physicians.

GEORGIA
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
X				X			X			

- = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

Georgia

PROGRAM (Date Initiated): Joint Board of Family Practice

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: Steve Cole, Administrator
Address: Joint Board of Family Practice
6065 Roswell Road, N.E. - Suite 502
North Side Towers
Atlanta, GA 30327
Telephone: 404-894-5168

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Primary Care Residencies

NARRATIVE DESCRIPTION:

Established by the Georgia Assembly as a "method of increasing the number of family physicians to provide needed medical service to the people of Georgia," the Joint Board of Family Practice is composed of licensed physicians, including representatives of the Board of the Georgia Academy of Family Practice and state medical schools having a department of family practice, and one designee each from the state medical and state osteopathic associations. The Board is authorized to identify family physician shortage areas, to assure compliance of family practice residency programs with national accreditation requirements and standards, and monitor the programs to allocate appropriated state funds for family practice residency programs, and to develop programs to encourage family practice education for medical students as well as practitioners of medicine.

GOALS:

1. Increase the number of physicians in primary care and/or family practice.
2. Increase access to medical care in underserved urban and rural areas.
3. Attract physicians to underserved urban and rural areas.

PARTICIPATING INSTITUTIONS: Medical school, graduate medical training program, hospital, group practice, private practice.

CLINICAL SPECIALTIES: Family practice

AREA SELECTION CRITERIA:

STANDARDS FOR
PROGRAM EVALUATION: Number of participants remaining in state.

OUTCOME: 77% of participating remain in state.



Georgia

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$4,000,000	\$4,300,000	\$4,800,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #		137	123
% In-State Residents			
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

Georgia

PROGRAM (Date Initiated): The State Medical Education Board of Georgia
Scholarship Program (1952)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Joseph Lawley, M.D.
Assistant Executive Secretary
Address: State Medical Education Board of Georgia
244 Washington Street, S.W.
Atlanta, GA 30334
Telephone: 404-656-2228

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES: Service-contingent Loans and Scholarships**

NARRATIVE DESCRIPTION:

The Georgia State Medical Education Board Program was established to assure increased health care delivery in rural areas of the state and to provide a program of aid to undergraduate medical students in need of financial assistance. The program provides scholarships to recipients who contractually agree to repay through service in a community in Georgia having 15,000 people or fewer. The recipient may also repay through service by practicing at any facility under the auspices of the state Department of Human Resources or Department of Corrections.

GOALS:

1. Attract physicians to underserved rural areas.
2. Reduce financial barriers to medical training for state residents.
3. Retain state medical graduates within the state.

PARTICIPATING INSTITUTIONS: Medical school.

ELIGIBILITY: State resident, financial need, commitment to practice in medically underserved or shortage area, commitment to primary care, commitment to practice in the state, acceptance in a 4-year medical school.

AREA SELECTION CRITERIA: Community size: 15,000 or fewer population.

Georgia

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ None	\$6,000	\$6,000	\$24,000	4
<u>SERVICE OBLIGATION</u>		<u>BUYOUT PROVISIONS</u>		
1 year of service for each year of aid.		Triple payment penalty at market interest rate due in 90 days.		

STANDARDS FOR
PROGRAM EVALUATION: Proportion of participants who remain in the state.

OUTCOME: 70% remain in the state.

<u>ANNUAL FUNDING LEVELS:</u>	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	\$500,000	\$500,000	\$500,000

CURRENT SOURCE OF FUNDING: (PERCENT)	FEDERAL: 0%
	STATE: 100%
	LOCAL: 0%
	PRIVATE: 0%
	TOTAL: 100%

<u>PARTICIPANT PROFILE:</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #		32	34
% In-State Residents		100	100
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

Georgia

PROGRAM (Date Initiated): Physician Recruitment and Placement Program
(1977)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: Joyce Butler, Director
Address. Medical Association of Georgia
938 Peachtree Street
Atlanta, GA 30309
Telephone: 404-876-7535

TYPE OF INCENTIVE: AID IN PRACTICE: Placement

NARRATIVE DESCRIPTION:

The Medical Association of Georgia maintains a computerized placement service to match physicians seeking practice opportunities with communities in need.

GOALS:

1. Attract physicians to underserved urban and rural areas.
2. Increase the number of physicians in primary care.
3. Increase access to care in underserved urban and rural areas.

PARTICIPATING INSTITUTIONS: Medical school, graduate medical training program, hospital association, municipal association.

CLINICAL SPECIALTIES: All

AREA SELECTION CRITERIA: HMSA used elsewhere by state but not part of this program's requirements.

STANDARDS FOR
PROGRAM EVALUATION: None

OUTCOME: Not measured

ANNUAL FUNDING LEVELS:	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	\$1,800	\$2,000	\$2,000

Georgia

CURRENT SOURCE OF FUNDING: (PERCENT)	FEDERAL: 0%
	STATE: 0%
	LOCAL: 0%
	PRIVATE: 100%
	TOTAL: 100%

PARTICIPANT PROFILE:	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	150	150	150
% In-State Residents	_____	_____	_____
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

Georgia

PROGRAM (Date Initiated): CompHealth, Inc.

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: Therus C. Kolff, M.D., President
 Address: CompHealth, Inc.
 5901 Peachtree Dunwoody Road, Suite C-65
 Atlanta, Georgia 30328
 Telephone: 404-391-9876/1-800-354-4050

TYPE OF INCENTIVE: AID IN PRACTICE: Placement

NARRATIVE DESCRIPTION:

Comprehensive Health Systems is a Georgia-based recruitment and placement organization which provides national locum tenens physician services. A geographically diverse group of physicians representing primary care and all other specialties, are matched to individual practices during physician leaves due to vacation, continuing medical education or for any other reason. CompHealth arranges hospital privileges and coordinates travel and housing as well as paying the physician's salary, malpractice insurance and licensure costs. CompHealth utilized a locum tenens approach in placing physicians in underserved areas on a permanent basis.

GOALS:

1. Match physicians to communities in need.
2. Provide a temporary service for physicians.

PARTICIPATING INSTITUTIONS: Hospitals, group practices, private practices.

CLINICAL SPECIALTIES: All

AREA SELECTION CRITERIA:

STANDARDS FOR
 PROGRAM EVALUATION:

OUTCOME:

ANNUAL FUNDING
 LEVELS:

	FY 1983	FY 1984	FY 1985
	\$	\$	\$

CURRENT SOURCE
 OF FUNDING:
 (PERCENT)

FEDERAL:	0%
STATE:	0%
LOCAL:	0%
PRIVATE:	100%
TOTAL:	100%

Georgia

PARTICIPANT
PROFILE:

	1983	1984	1985
Total #			
% In-State Residents			
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

IDAHO
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
	X									

- X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

Idaho

PROGRAM (Date Initiated): Washington, Alaska, Montana, Idaho (WAMI) (1971)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Mark DeSantis, Ph.D., Interim Director

Address: WAMI Program
University of Idaho
Moscow, ID 83843

Telephone: 208-885-6696

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Seat Purchase

NARRATIVE DESCRIPTION:

WAMI is a program in Washington, Alaska, Montana and Idaho whose purpose is to guarantee access to medical school to qualified students from the four states and is designed to expose students to medical practice outside of metropolitan areas. Students from the participating states enroll at the University of Washington School of Medicine, the only public medical school in the four states, but take basic science courses on their "home" campuses (e.g., University of Idaho) for the first year. After the first year, they move to the Seattle Campus. In the third and fourth years, students may elect to take six weeks of primary care clinical training with community physicians in 12 different locations (2 in Idaho) within the four-state area. Physicians providing clerkship training are appointed to the School of Medicine faculty, allowing them continuing educational opportunities there.

The participating states bear their respective shares of the program costs and in return benefit from the increased availability of physicians without the cost of constructing, equipping and staffing medical schools. The states also have a similar arrangement with the University of Washington for physician's assistants.

GOALS:

1. Provide access to medical school for qualified applicants.
2. Attract physicians to primary care practice in non-metropolitan areas.
3. Increase the number of practicing physicians in states without medical schools.

PARTICIPATING INSTITUTIONS: Medical schools, colleges, hospitals, ambulatory care facilities, group practices, private practices

CLINICAL SPECIALTIES: Internal medicine, ob/gyn, family practice, pediatrics

Idaho

AREA SELECTION CRITERIA:

STANDARDS FOR
PROGRAM EVALUATION:

Number of state residents in medical school.

OUTCOME: 1983: 20 enrolled in medical school
 1984: 18 enrolled in medical school
 1985: 17 enrolled in medical school

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$2,106,262	\$2,249,204	\$2,356,264

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 100%
LOCAL: 0%
PRIVATE: 0%
TOTAL: 100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	80	77	74
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	77/23	74/26	74/26
% Minority	_____	_____	_____

ILLINOIS
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
X				X						

X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

Illinois

PROGRAM (Date Initiated): Illinois Family Practice Residency Act
Scholarship Program (1977)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: George S. Rudis, Acting Chief
Address: Division of Local Health Administration
Illinois Department of Public Health
525 W. Jefferson Street
Springfield, IL 62706
Telephone: 217-785-4357

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Primary Care Residencies

NARRATIVE DESCRIPTION:

The Family Practice Residency Act Scholarship Program provides grants for two programs: residencies in family practice and scholarships to undergraduate medical students (the latter is described in another section). Funds are provided for special projects developed by residency programs to extend health care services into underserved areas. Such areas may be HMSAs, MUAs, or areas meeting the department criteria described in Chapter Three. Special projects serve dual purposes: providing health care otherwise unavailable in an underserved area, and providing an education experience for the family practice residents similar to that which they would experience when establishing a practice in an underserved area.

During 1982, 1983, and 1984, no funds were awarded under the program due to state budget constraints. However, in 1985 and 1986 funds were restored.

GOALS:

1. Retain state medical graduates within state.
2. Increase number of physicians in Family Practice.
3. Improve access to primary care in the state.

PARTICIPATING INSTITUTIONS: Medical Schools, hospitals, graduate medical training programs.

CLINICAL SPECIALTIES: Family Practice

AREA SELECTION CRITERIA: HMSA, MUA or State Criteria (see Chapter Three).

STANDARDS FOR PROGRAM EVALUATION: Number of state medical graduates remaining in the state.

Illinois

OUTCOME: None formal, but many participants ultimately locate outside of Illinois.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$ 0	\$ 0	\$700,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 100%
LOCAL: 0%
PRIVATE: 0%
TOTAL: 100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #			
% In-State Residents			
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

Illinois

PROGRAM (Date Initiated): Illinois Family Practice Residency Act
Scholarship Program (1977)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: George S. Rudis, Acting Chief
Address: Division of Local Health Administration
Illinois Department of Public Health
525 W. Jefferson Street
Springfield, IL 62706
Telephone: 217-785-4357

TYPE OF INCENTIVE: FINANCIAL INCENTIVES: Service-contingent Loans and
Scholarships

NARRATIVE DESCRIPTION:

The Family Practice Residency Act Scholarship program provides grants for two programs for the purpose of upgrading primary health care throughout the state of Illinois. The medical scholarship program detailed here provides scholarships to undergraduate medical students in return for service in primary care in a state-designated underserved area upon completion of residency.

During 1982, 1983 and 1984, no funds were granted to the scholarship program, and no scholarships were awarded. However, in 1985 and 1986, funds have been restored.

GOALS:

1. Upgrade primary health care services for all state residents.
2. Reduce financial barriers for state residents interested in medical careers.

PARTICIPATING INSTITUTIONS: Medical schools.

ELIGIBILITY: State resident, financial need, (minority status considered in decisions), commitment to practice in medically underserved area of the state, interest in primary care, scholastic ability, enrolled in an Illinois medical school, exposure to populations considered underserved.

AREA SELECTION CRITERIA: HMSA, MUA or State Criteria (see Chapter Three).

Illinois

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ None	Stipend of \$600/month + tuition	At state schools, \$12,000. At private schools, \$25,000.	None specified	4

SERVICE OBLIGATION

One year for each year of
aid.

BUYOUT PROVISIONS

3 times the amount of principal
payable in the number of years
that received aid.

STANDARDS FOR

PROGRAM EVALUATION:

Number of participants fulfilling service obligations.

OUTCOME:

Only 3 students have defaulted on their obligations;
however, the program is so new that it is hard to
measure outcomes.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$ 0	\$ 0	\$1,000,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 100%
LOCAL: 0%
PRIVATE: 0%
TOTAL: 100%

PARTICIPANT PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	<u>0</u>	<u>0</u>	59
% In-State Residents	<u>0</u>	<u>0</u>	100
% Training/ Practicing in Rural Setting	<u>0</u>	<u>0</u>	
% Rural Origin	<u>0</u>	<u>0</u>	
% Male/Female	<u>0</u>	<u>0</u>	42/58
% Minority	<u>0</u>	<u>0</u>	43

Illinois

PROGRAM (Date Initiated): Illinois Medical Student Loan Fund (1948)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: James Schmidt, Director of Special Services
Address: Illinois Farm Bureau
1701 Towanda Avenue
Bloomington, IL 61701
Telephone: 301-557-2538

TYPE OF INCENTIVE: FINANCIAL INCENTIVES: Service-contingent Loans and Scholarships

NARRATIVE DESCRIPTION:

This program is sponsored jointly by the Illinois Medical Society and the Illinois Farm Bureau, for the purpose of helping qualified medical school students overcome financial need obstacles. The program tries to encourage students to enter primary care practice in rural areas of Illinois. The program gives loans, which will be forgiven for one year of service in an area with population less than 35,000 in a primary care specialty for each year of loan.

GOALS:

1. Reduce financial barriers to medical training for state residents.
2. Retain state medical graduates within the state.
3. Attract physicians to primary care in rural areas.

PARTICIPATING INSTITUTIONS: Medical Society, Farm Bureau.

ELIGIBILITY: State resident, financial need, commitment to primary care practice in Illinois, signatures of County Medical Society and County Farm Bureau.

AREA SELECTION CRITERIA: Community size: population fewer than 35,000 in a primary care specialty.

Illinois

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$0	\$2,500	\$2,000	\$10,000	4

SERVICE OBLIGATION

1 year of service in area with population less than 35,000 in a primary care specialty for each year of of loan.

BUYOUT PROVISIONS

Liquidated damages + interest, payable immediately.

STANDARDS FOR
PROGRAM EVALUATION:

Number of participants fulfilling service obligations.

OUTCOME:

Approximately 80 percent of participants fulfill their obligations.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$28,000	\$33,000	\$32,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 0%
LOCAL: 0%
PRIVATE: 100%
TOTAL: 100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	12	9	16
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting			
% Rural Origin	83	78	88
% Male/Female			
% Minority			

INDIANA
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
-				-						

- X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

IOWA

STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
X										

X = Presence of program.

+ = Program added since 1981.

- = Program discontinued since 1981.

Iowa

PROGRAM (Date Initiated): **Statewide Family Practice Education Program
(1973)**

ADMINISTRATIVE LOCUS: **State**

ADMINISTRATOR:

Director/Contact Person: Paul M. Seebohm, M.D.
Executive Associate Dean
Address: University of Iowa College of Medicine
120 CMAB
Iowa City, IA 52242
Telephone: 319-353-5117

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Primary Care Residencies

NARRATIVE DESCRIPTION:

Legislation enabling a statewide network of community-based family practice residency programs, enacted in 1973, has created nine residency programs in seven communities. All but two of the programs are affiliated with the University of Iowa College of Medicine for educational and technical support. The state pays a capitated amount per FTE resident to each residency program; the funds may be used to pay residents' stipends or for educational purposes. Both allopathic and osteopathic medical graduates are eligible for the residencies.

GOALS:

1. Increase the number of family physicians trained in the state.
2. Retain family physicians in Iowa and distribute to rural areas.
3. Create a community-based focus for the College of Medicine undergraduate experiences and cooperative clinical research.

PARTICIPATING INSTITUTIONS: Hospitals in Des Moines (3), Sioux City, Mason City, Waterloo, Cedar Rapids, Davenport, and Iowa City.

CLINICAL SPECIALTIES: **Family Practice**

AREA SELECTION CRITERIA:

STANDARDS FOR

PROGRAM EVALUATION: Retention of residents in Iowa, particularly in rural areas.

Iowa

OUTCOME: In 1985, 66% of graduates set up practice in state. The 11-year average retention is 60%. During that time, 50% chose to practice in towns of 10,000 or less.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$1,382,080*	\$1,392,900*	\$1,392,900*

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%*
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

* State contribution only. This supports only about 7.5% of total program costs. The remainder comes from federal training grants (1.0%), practice income (39.0%), hospital support (50.0%), and other (2.5%).

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	170*	180*	180**
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

* Estimate

** 148 MD, 32 DO

KANSAS
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
X	-	X		X			X			X

X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

Kansas

PROGRAM (Date Initiated): Family Practice Residency Program (1970)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: James Price, MD, Chairman
Address: Department of Family Practice
University of Kansas
Kansas City, KS 66103
Telephone: 913-588-1900

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Primary Care Residencies

NARRATIVE DESCRIPTION:

In order to increase the number of family physicians, the University of Kansas Medical Center has a residency program in Family Medicine in Kansas City, which has 37 residents, and four affiliated programs in Wichita through the University of Kansas in Wichita, which have 68 residents.

GOALS: 1. Increase the number of Kansas medical school graduates in family practice.

PARTICIPATING INSTITUTIONS: Medical schools, hospitals.

CLINICAL SPECIALTIES: Family Practice

AREA SELECTION CRITERIA:

STANDARDS FOR
PROGRAM EVALUATION:

OUTCOME:

ANNUAL FUNDING
LEVELS:

	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	<u>\$ *</u>	<u>\$ *</u>	<u>\$ *</u>

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%*
STATE:	0%*
LOCAL:	0%*
PRIVATE:	<u>0%*</u>
TOTAL:	0%*

* The state pays stipends to the 37 residents at the Kansas City program; affiliated hospitals pay stipends to residents in the Wichita programs.

Kansas

**PARTICIPANT
PROFILE:**

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	104*	104*	104*
% In-State Residents	_____	_____	_____
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

* Across 5 programs: 37 in Kansas City and 68 in 4 Wichita-affiliated programs.

PROGRAM (Date Initiated): Preceptorship (1950)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: James Price, M.D., Chairman
Department of Family Practice
Address: University of Kansas Medical Center
39th and Rainbow Boulevard
Kansas City, KS 66103
Telephone: 913 588-1900

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Preceptorships

NARRATIVE DESCRIPTION:

The University of Kansas School of Medicine requires fourth-year undergraduate medical students to spend one month in an off-site preceptorship with a practicing physician. The purpose of the preceptorship is to acquaint students with the clinical aspects of medical practice. This preceptorship program is one of the oldest in the country.

GOALS: 1. Acquaint students with clinical practice.

PARTICIPATING INSTITUTIONS: Medical school, hospitals, group practices, private practices.

CLINICAL SPECIALTIES:

AREA SELECTION CRITERIA:

STANDARDS FOR
PROGRAM EVALUATION:

OUTCOME: None specified.

ANNUAL FUNDING
LEVELS:

	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	\$ 0	\$ 0	\$ 0

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	0%
LOCAL:	0%
PRIVATE:	<u>0%</u>
TOTAL:	0%

Kansas

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	200	200	200
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	<u> </u>	<u> </u>	<u> </u>
% Rural Origin	<u> </u>	<u> </u>	<u> </u>
% Male/Female	<u> </u>	<u> </u>	<u> </u>
% Minority	<u> </u>	<u> </u>	<u> </u>

Kansas

PROGRAM (Date Initiated): Kansas Medical Scholarship Program (1978)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: A.J. Yarmat, Ph.D., Director of Student Affairs
Address: University of Kansas Medical Center
39th and Rainbow Boulevard
Kansas City, KS 66103
Telephone: 913-588-4698

TYPE OF INCENTIVE: FINANCIAL INCENTIVES: Service-contingent Loans and Scholarships

NARRATIVE DESCRIPTION:

In 1978 the Kansas legislature authorized two types of scholarships to be available to medical students attending the University of Kansas School of Medicine in return for practice within the state. The type of assistance varies according to the area in which the student agrees to serve. Currently, Type I scholarship recipients receive full tuition plus a \$500 monthly stipend. In return, they agree to practice in a critically underserved area for one year for each year of support. Type II recipients receive full tuition in return for agreement to practice in a medically underserved area for one year for each year of support.

The service areas were redefined in 1982 in response to a decline in manpower shortage in the state. Previously, Type II recipients could practice anywhere in the state, and Type I could practice in a medically underserved area. In 1983, the legislature capped the number of scholarships to be given per year to 50 per entering class, in light of the improving physician manpower in Kansas.

- GOALS:**
1. Retain state medical graduates within the state.
 2. Attract physicians to underserved areas.
 3. Achieve a balance of physician supply with need or demand for medical care.

PARTICIPATING INSTITUTIONS: Medical school, state health agency.

ELIGIBILITY: Admitted/enrolled in University of Kansas School of Medicine, commitment to practice in the state, commitment to practice in medically underserved or critically underserved area.

AREA SELECTION CRITERIA: Physician-to-population ratio: Thresholds for primary care in 1985 were 33.3:100,000 for critical underservice; 36.3:100,000 for medical underservice.

Kansas

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ tuition	\$ tuition + \$4,500 stipend	\$9,000	\$ 4 years of tuition + stipend	4
<u>SERVICE OBLIGATION</u>		<u>BUYOUT PROVISIONS</u>		
One year for each year of aid. For Type I Scholarship, service must be in critically underserved area; for Type II, service must be be in medically under- served area.		Principal + 15% interest accruing from year of loan, payable within 10 years.		

STANDARDS FOR

PROGRAM EVALUATION: Number of participants fulfilling service obligations.

OUTCOME: 40 percent of participants fulfill their obligations.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$3,100,000	\$3,100,000	\$3,100,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	330	330	330
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female	67/33	67/33	67/33
% Minority	*	*	*

*Statistically insignificant figure

Kansas

PROGRAM (Date Initiated): Kansas Osteopathic Loan Program (1978)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Gene Kasper, Ph.D., Director of Special Projects
Kansas Board of Regents
Address: Capitol Tower
400 W. Eighth, Suite 609
Topeka, KS 66603
Telephone: 913-296-3517

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES:** Service-contingent Loans and Scholarships

NARRATIVE DESCRIPTION:

The Kansas Osteopathic Loan Program was established by the Kansas legislature for the purpose of giving scholarships to Kansas residents who are undergraduate osteopathic students. This program currently funds 10 new scholarships per year, giving priority to freshman students. Students can attend school anywhere in the United States. The program will forgive the complete amount of the scholarship in return for one year of practice in the state in a primary care practice for each year of financial assistance.

GOALS:

1. Retain state medical graduates within the state.
2. Reduce financial barriers to medical training for state residents.
3. Increase the number of physicians in primary care specialties.

PARTICIPATING INSTITUTIONS: Medical schools.

ELIGIBILITY: Kansas resident, financial need, commitment to practice in state, commitment to primary care.

AREA SELECTION CRITERIA: Anywhere in the state in a primary care specialty.

Kansas

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ None	\$10,000	\$10,000	\$40,000	4
<u>SERVICE OBLIGATION</u>		<u>BUYOUT PROVISIONS</u>		
One year of practice in primary care in state for each year of aid.		Principal + 15% interest accruing from time of loan, payable within 10 years.		

STANDARDS FOR
PROGRAM EVALUATION: Number of participants practicing in state.

OUTCOME: 50 percent of participants continue to practice in
state.

<u>ANNUAL FUNDING LEVELS:</u>	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	\$150,000	\$250,000	\$341,691

CURRENT SOURCE OF FUNDING: (PERCENT)	FEDERAL: 0%
	STATE: 100%
	LOCAL: 0%
	PRIVATE: 0%
	TOTAL: 100%

<u>PARTICIPANT PROFILE:</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	14	24	35
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

Kansas

PROGRAM (Date Initiated): Out-of-Phase Physician Program (1978)

ADMINISTRATIVE LOCUS: Kansas Board of Healing Arts

ADMINISTRATOR:

Director/Contact Person: Charlene Abbott, Executive Secretary
Address: Kansas Board of Healing Arts
503 Kansas Avenue, Suite 500
Topeka, KS 66603
Telephone: 913-296-7413

TYPE OF INCENTIVE: **AID IN PRACTICE: Placement**

NARRATIVE DESCRIPTION:

On a limited basis, the State Board of Healing Arts may approve practice by a physician who has completed undergraduate training in a branch of the healing arts and has not engaged in a full-time approved postgraduate training program. Such an individual must be sponsored by a physician in a designated rural community who will oversee the activities of the "Out-of-Phase" physician. The holder of the special permit cannot practice independently and is compensated by his/her sponsor for services provided. Permits are issued for a one-year term and expire if the holder enters postgraduate training.

GOALS:

1. Increase number of physicians in family practice.
2. Attract physicians to underserved rural areas.

PARTICIPATING INSTITUTIONS: Medical schools, group practices, private practices.

CLINICAL SPECIALTIES: None specified.

AREA SELECTION CRITERIA: Other: rural community and physician sponsor are approved on a case-by-case basis.

STANDARDS FOR
PROGRAM EVALUATION: None specified.

OUTCOME: 5 physicians per year placed.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$ 0	\$ 0	\$ 0

Kansas

CURRENT SOURCE	FEDERAL:	0%
OF FUNDING:	STATE:	0%
(PERCENT)	LOCAL:	0%
	PRIVATE:	0%
	TOTAL:	0%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	5	5	5
% In-State Residents	_____	_____	_____
% Training/ Practicing in Rural Setting	100	100	100
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

Kansas

PROGRAM (Date Initiated): Physician Placement Program (1977)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: A.J. Yarmat, Ph.D., Director of Student Affairs
Address: University of Kansas Medical Center
39th and Rainbow Boulevard
Kansas City, KS 66103
Telephone: 913-588-4698

TYPE OF INCENTIVE: AID IN PRACTICE: Placement

NARRATIVE DESCRIPTION:

This community-physician placement service focuses on physicians and allied health professions placement by maintaining a roster and serving as a matching service for communities in need and physicians seeking practice locations. Initially, communities lacking health manpower were identified by means of a questionnaire; currently, the roster is updated by communications with hospitals, group practices, businessmen, and others throughout the state. In addition, the Kansas Medical Society cooperates with the program.

- GOALS:
1. Attract physicians to underserved rural areas.
 2. Increase access to medical care in underserved rural areas.
 3. Balance physician supply with demand.

PARTICIPATING INSTITUTIONS: Medical school, graduate medical training programs, colleges and universities, communities.

CLINICAL SPECIALTIES: None specified.

AREA SELECTION CRITERIA:

STANDARDS FOR PROGRAM EVALUATION: None specified.

OUTCOME: Although no formal outcomes are measured, the program has placed at least 200 physicians in its 8 years' of existence.

ANNUAL FUNDING LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$5,000	\$5,000	\$5,000

Kansas

CURRENT SOURCE	FEDERAL:	0%
OF FUNDING:	STATE:	100%
(PERCENT)	LOCAL:	0%
	PRIVATE:	0%
	TOTAL:	100%

NOT RELEVANT TO THIS PROGRAM

PARTICIPANT PROFILE:	1983	1984	1985
Total #			
% In-State Residents			
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

Kansas

PROGRAM (Date Initiated): Kansas AHEC Program (1977)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: D. Kay Clawson, M.D.
Executive Vice Chancellor
Address: University of Kansas Medical Center
39th and Rainbow Boulevard
Kansas City, KS 66103
Telephone: 913-588-1400

TYPE OF INCENTIVE: AID IN PRACTICE: AHECs

NARRATIVE DESCRIPTION:

The Kansas AHEC program is currently state funded. The program has five sites, which focus primarily on providing continuing medical education for physicians and allied health professions. The sites also have outreach efforts to encourage physicians and allied health professionals to locate in rural and underserved urban areas.

GOALS:

1. Provide continuing medical education to practitioners located in rural or underserved urban areas.
2. Encourage practitioners to locate in rural or underserved urban areas.
3. Increase access to care in rural underserved urban areas.

PARTICIPATING INSTITUTIONS: Medical schools, graduate training programs, hospitals, ambulatory care facilities, group practices, private practices.

CLINICAL SPECIALTIES:

AREA SELECTION CRITERIA:

**STANDARDS FOR
PROGRAM EVALUATION:**

OUTCOME:

Kansas

**ANNUAL FUNDING
LEVELS:**

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$900,000*	\$900,000*	\$900,000*

* Excluding funds received for Continuing Medical Education services at Kansas City and Wichita affiliated sites, which are included in those universities' operating budgets.

CURRENT SOURCE	FEDERAL:	0%
OF FUNDING:	STATE:	100%
(PERCENT)	LOCAL:	0%
	PRIVATE:	0%
	TOTAL:	100%

NOT RELEVANT TO THIS PROGRAM

**PARTICIPANT
PROFILE:**

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	_____	_____	_____
% In-State Residents	_____	_____	_____
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

KENTUCKY
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
X			X	X						X

X = Presence of program.

+ = Program added since 1981.

- = Program discontinued since 1981.

Kentucky

PROGRAM (Date Initiated): Primary Care Residency Program (1976)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Larry Fowler, Director for Special Programs
Address: Council on Higher Education
1050 U.S. 127 South
Franklin, KY 40601

Telephone: 502-564-3745

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Primary Care Residencies

NARRATIVE DESCRIPTION:

The Primary Care Residency Program was established by the Kentucky legislature to increase the number of primary care residencies available to graduate medical students in the state of Kentucky. Funding supports 52 positions at each of two medical schools. To increase exposure to non-metropolitan areas, residents receiving support under this program must spend 3 months out of their 3-year residency training program at a training site remote from the counties in which the medical schools are located.

GOALS:

1. Increase the number of physicians in primary care.
2. Attract physicians to underserved rural areas.
3. Increase access to care in underserved rural areas.

PARTICIPATING INSTITUTIONS: Medical Schools, Graduate Medical Training Program, Hospitals.

CLINICAL SPECIALTIES: General Practice, Internal Medicine, Family Practice, Pediatrics, OB/Gyn, Public Health

AREA SELECTION CRITERIA: Other: county other than those in which medical schools are located (all of these are non-metropolitan).

STANDARDS FOR PROGRAM EVALUATION: None specified.

OUTCOME: Currently 104 residents.

Kentucky

ANNUAL FUNDING LEVELS:	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	\$3,328,000	\$3,328,000	\$3,328,000
CURRENT SOURCE OF FUNDING: (PERCENT)	FEDERAL: 0% STATE: 100% LOCAL: 0% PRIVATE: 0% TOTAL: 100%		
PARTICIPANT PROFILE:	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	104	104	104
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	<u>*</u>	<u>*</u>	<u>*</u>
% Rural Origin	<u> </u>	<u> </u>	<u> </u>
% Male/Female	<u> </u>	<u> </u>	<u> </u>
% Minority	<u> </u>	<u> </u>	<u> </u>

* All residents must do a portion of training in a non-metropolitan area.

Kentucky

PROGRAM (Date Initiated): Professional Education Preparation Program
(PEPP) (1980)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Larry Fowler, Director for Special Programs
Address: Kentucky Council on Higher Education
1050 U.S. 127 South
Frankfort, KY 40601
Telephone: 502-564-5483

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Other Curriculum Changes

NARRATIVE DESCRIPTION:

The Kentucky legislature authorized the PEPP to award grants to educational institutions to increase the number of individuals from HMSAs who are accepted to and succeed in medical or dental school. Participating institutions are Kentucky State University, The University of Kentucky, and the University of Louisville. One program, directed at new high school graduates, consists of 5-7 week summer workshop sessions which include instruction in biology, mathematics, chemistry, and writing. In addition, students are taught study skills and receive some clinical experience. Another program consists of 5-week summer sessions for students who have completed 2 years of college; the program focuses on preparation for professional school admissions tests. The PEPP also runs assessment conferences, which take place over weekends in the fall and spring, where PEPP participants return to a campus to continue their identification with the program and evaluate their performances. Practice MCAT/DAT seminars are offered each January for students who wish to prepare for the admissions tests. Finally, PEPP staff members assist students in finding health-related summer employment.

GOALS: 1. Increase the proportion of students from health manpower shortage counties who apply to, are accepted by, and graduate from medical and dental school.

PARTICIPATING INSTITUTIONS: Colleges, universities.

CLINICAL SPECIALTIES: None specified.

AREA SELECTION CRITERIA: HMSA

STANDARDS FOR FOR
PROGRAM EVALUATION: Number of PEPP participants entering medical or dental school.

OUTCOME: Too soon to draw any meaningful conclusions.

Kentucky

ANNUAL FUNDING LEVELS:	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	\$250,000	\$250,000	\$250,000
CURRENT SOURCE OF FUNDING: (PERCENT)	FEDERAL: 0% STATE: 100% LOCAL: 0% PRIVATE: 0% TOTAL: 100%		
PARTICIPANT PROFILE:	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	65	65	65
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting			
% Rural Origin	95	95	95
% Male/Female	50/50	50/50	50/50
% Minority	5	5	5

Kentucky

PROGRAM (Date Initiated): Rural Kentucky Medical Scholarship Fund (1946)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: Eileen Dougherty, Executive Secretary
Address: Kentucky Medical Association
3532 Ephraim Street
Louisville, KY 40205
Telephone: 502-459-9790

TYPE OF INCENTIVE: FINANCIAL INCENTIVES: Service-contingent Loans and Scholarships

NARRATIVE DESCRIPTION:

The Rural Scholarship Fund is a private revolving fund of the Kentucky Medical Association designed to assist medical students who are willing to practice in rural areas of Kentucky and who need financial assistance. The loans will be forgiven if a student agrees to practice in a program-designated critically underserved area for one year for each year of assistance.

- GOALS:**
1. Reduce barriers to medical training for state residents.
 2. Increase access to care in underserved areas.
 3. Attract physicians to underserved rural areas.

PARTICIPATING INSTITUTIONS: Medical Schools.

ELIGIBILITY: State resident, financial need, attend University of Kentucky or University of Louisville, commitment to primary care, commitment to practice in state.

AREA SELECTION CRITERIA: Physician-to-population ratio: the program directors measure physician-to-population ratios by county; critical underservice currently defined as 1:4,500 or greater. (This is similar to the state's method of assessing underservice, but the program directors modify the state's definition according to their own list of critical counties, which takes geographical factors into account on a case-by-case basis.)

Kentucky

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$0	\$5,000	\$5,000	\$20,000	4
<u>SERVICE OBLIGATION</u>		<u>BUYOUT PROVISIONS</u>		
One year for each year of financial assistance.		Principal + interest + \$5,000 payable within 60 days.		

STANDARDS FOR

PROGRAM EVALUATION:

Number of participants practicing in state.

OUTCOME:

56 percent of all recipients over the life of the
program currently practice in state.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$120,000	\$120,000	\$120,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 0%
LOCAL: 0%
PRIVATE: 100%
TOTAL: 100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	24	24	24
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

Kentucky

PROGRAM (Date Initiated): Area Health Education Center (1974)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Michael E. Byrne, Director of Special Programs
Address: University of Louisville School of Medicine
Louisville, KY 40292
Telephone: 502-588-7159

Director/Contact Person: James C. Norton, Ph.D.
Address: Associate Director AHEC
University of Kentucky
Chandler Medical Center
Lexington, KY 40536
Telephone: 606-233-8018

TYPE OF INCENTIVE: AID IN PRACTICE: AHECs

NARRATIVE DESCRIPTION:

The Kentucky Council on Higher Education originally established the AHES (Area Health Education System) program in 1974 for the purpose of enabling health sciences students to take a portion of their medical training in a rural area of the state. Under the program, students spend 4-8 weeks working and learning under the direction of a rural health practitioner. In 1982-83, the Council's role was markedly decreased, and state funds began to go directly to the two universities involved in program administration.

In 1984, the University of Louisville and the University of Kentucky applied for and received federal funding for the establishment of four rural AHECs. The first year of federal funding was 1986. Currently, there are 3 AHEC sites in Kentucky; a fourth site will be established in October 1986.

- GOALS:**
1. Emphasize and promote primary care.
 2. Improve the quality of care especially in rural underserved areas.
 3. Regionalize some health sciences education.

PARTICIPATING INSTITUTIONS: Medical school, graduate medical training programs, hospitals, practicing physicians, public health department, clinics.

CLINICAL SPECIALTIES: Primary care.

AREA SELECTION CRITERIA: HMSA

Kentucky

STANDARDS FOR

PROGRAM EVALUATION:

Currently being developed; will include physician/specialty distribution (rural/urban; in-state/out-of-state) of participants.

OUTCOME:

Under the original state-funded AHES program, between 1974 and 1980, it was found that increased numbers of practitioners training at Kentucky universities eventually established practice in AHES regions. However, students first participated in 1976, and outcomes as to practice locations are not available yet. This is currently under study.

ANNUAL FUNDING
LEVELS:*

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$1,500,000	\$1,500,000	\$1,500,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

* FY 1986 was the first year of federal grant funds: \$284,485 in addition to the state funds.

NOT RELEVANT TO THIS PROGRAM

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	_____	_____	_____
% In-State Residents	_____	_____	_____
% Training/Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

LOUISIANA
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
		-					-			

- X = Presence of program.
 * = Program added since 1981.
 - = Program discontinued since 1981.

MAINE
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
-	X		-	X		X				X

X = Presence of program.

+ = Program added since 1981.

- = Program discontinued since 1981.

- 132 -

Maine

PROGRAM (Date Initiated): Postgraduate Health Professions Program (1976)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Ann Crandall, Consultant
Address: Department of Educational and Cultural
Services, Higher Education Services
Station 119
Augusta, ME 04333
Telephone: 207-289-2183

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Seat Purchase

NARRATIVE DESCRIPTION:

Since Maine does not have an allopathic medical school or dental school, the legislature has authorized funds to secure a number of seats at the University of Vermont and Tufts Medical School and Tufts Dental School for Maine residents. The state pays each school a fixed fee (seat purchase) per student, which the school can apply to defray the costs of tuition or use for other costs of education. The student is responsible for repayment of the part of the fee that the school applies to tuition. For example, the 1985 fee for medical students was \$14,000 per student. The University of Vermont puts \$8,000 of this toward tuition and keeps \$6,000 for the costs of education. In this case, the student is responsible for paying the remainder of his/her tuition, and must repay the state of Maine the \$8,000 that was applied to tuition. The student does not enter repayment until the completion of professional training, including internship, residency, fellowship, obligated national service, or obligated public health service.

The program has a forgiveness clause: for each year of service in a designated underserved geographic area, specialty group, population group, or combination of these, 25 percent of the loan will be forgiven.

GOALS:

1. Provide access to allopathic medical and dental schools for Maine residents.
2. Balance physician and dentist supply with demand.

PARTICIPATING INSTITUTIONS: Medical schools, dental school

ELIGIBILITY: State resident for one year prior to application, acceptance at UVM or Tufts Medical School or Tufts Dental School

AREA SELECTION CRITERIA: HMSA modification: HMSA, geographic area, specialty group, population group, or any combination of these

Maine

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
	Negotiated annually	\$14,000 (class of 1989)		4
<u>SERVICE OBLIGATION</u>		<u>BUYOUT PROVISIONS</u>		
One year of service in a HMSA, specialty group, or population group for 25% forgiveness.		Principal + 9% interest payable in 10 annual payments.		

STANDARDS FOR FOR

PROGRAM EVALUATION: Number of participants fulfilling service obligations.

OUTCOME: 75 percent fulfill their service obligations.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$1,003,900*	\$ 965,000*	\$914,250*

* including \$114,000 dental in 1983.

* including \$ 68,000 dental in 1984.

* including \$ 95,500 dental in 1985.

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #*	116	87	76
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting			
% Rural Origin	50	50	50
% Male/Female	63/37	63/37	63/37
% Minority			

*18 allopathic and 2 dental students in each entering class.

Maine

PROGRAM (Date Initiated): Osteopathic Student Loan Program (1972)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Ann Crandall, Consultant
Address: Department of Educational and Cultural
Services, Higher Education Services,
Station 119
Augusta, ME 04333
Telephone: 207-289-2183

TYPE OF INCENTIVE: FINANCIAL INCENTIVES: Service-contingent Loans and
Scholarships

NARRATIVE DESCRIPTION:

The Osteopathic Loan Program was established by the Maine legislature in the 1970s. The program is administered by the state in cooperation with the Maine Osteopathic Association which screens applications and makes recommendations to the state. Low interest loans are awarded to Maine residents attending osteopathic school. Forgiveness of 25 percent per year is available to participants who locate their practice in HMSAs, underserved specialty groups, population groups, or any combination of these.

- GOALS:
1. Decrease financial barriers for state residents attending osteopathic school.
 2. Retain state medical graduates in the state.
 3. Increase the number of physicians in underserved areas in the state.

PARTICIPATING INSTITUTIONS: Any Osteopathic College or University accredited by the American Osteopathic Association.

ELIGIBILITY: State resident for 3 years, financial need, accepted to an accredited osteopathic program and shows a genuine interest in returning to Maine.

AREA SELECTION CRITERIA: HMSA Modification: HMSA, underserved specialty group, population group, or any combination of these.

Maine

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$1,000	\$5,000	\$4,000	\$20,000	4
<u>SERVICE OBLIGATION</u>		<u>BUYOUT PROVISIONS</u>		
One year of service in designated underserved area for 25% forgiveness.		Principal + 9% interest payable in 10 annual payments.		

STANDARDS FOR FOR
PROGRAM EVALUATION:

OUTCOME:

<u>ANNUAL FUNDING LEVELS:</u>	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	\$ 60,000	\$ 90,000	\$120,000

<u>CURRENT SOURCE OF FUNDING: (PERCENT)</u>	FEDERAL: 0%
	STATE: 100%
	LOCAL: 0%
	PRIVATE: 0%
	TOTAL: 100%

<u>PARTICIPANT PROFILE:</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	20	23	29
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

Maine

PROGRAM (Date Initiated): Maine Osteopathic Association Annual Scholarship Program (1972)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: David A. Deturk, Executive Director
Address: Maine Osteopathic Association
303 State Street
Augusta, ME 04330
Telephone: 207-623-1101

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES: Other Scholarships**

NARRATIVE DESCRIPTION:

The Maine Osteopathic Association offers four scholarships per year to state residents demonstrating financial need to attend osteopathic school. The program was initiated prior to the establishment of the New England College of Osteopathic Medicine, when it was more difficult for Maine residents to attend osteopathic school.

GOALS:

1. Reduce financial barriers for state residents attending osteopathic school.
2. Increase the number of primary care physicians in the state.
3. Attract physicians to underserved areas.

PARTICIPATING INSTITUTIONS: Medical schools

ELIGIBILITY: Financial need, state resident, U.S. citizen

AREA SELECTION CRITERIA:

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$500	\$1,000	\$750	\$4,000	4
<u>SERVICE OBLIGATION</u>			<u>BUYOUT PROVISIONS</u>	

Maine

STANDARDS FOR FOR
PROGRAM EVALUATION:

OUTCOME:

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$3,000	\$3,000	\$3,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 0%
LOCAL: 0%
PRIVATE: 100%
TOTAL: 100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	4	4	4
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

Maine

PROGRAM (Date Initiated): Maine AHEC Program (1975)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Charles Lyons, M.D., Director
Address: Office of Health Professions Education
University of Southern Maine
221 Bailey Hall
Gorham, ME 04038
Telephone: 207-780-5224

TYPE OF INCENTIVE: AID IN PRACTICE: AHECs

NARRATIVE DESCRIPTION:

The Maine AHEC program was initially established and received federal funds for the purpose of providing Maine practitioners with continuing medical education and recruiting physicians to practice in rural Maine. For the last four years, the program has been in a "special initiative" phase and focuses on providing special programs to educate physicians, dentists, and nurses about social medicine issues, such as alcoholism and teen pregnancy. The program's aim now is more toward retention of physicians and dentists than toward recruitment.

GOALS:

1. Attract physicians to underserved areas.
2. Increase access to care in underserved areas.
3. Retain state medical graduates within the state.

PARTICIPATING INSTITUTIONS: Hospitals, medical schools, graduate training programs, practitioners.

CLINICAL SPECIALTIES:

AREA SELECTION CRITERIA: HMSA

STANDARDS FOR FOR
PROGRAM EVALUATION:

OUTCOME:

Maine

ANNUAL FUNDING LEVELS:	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	\$100,000*	\$100,000*	\$100,000*

* The program relies on "in-kind" contributions from local sources for a large part of its funding; however, these figures were not available for this report.

CURRENT SOURCE	FEDERAL: 100%
OF FUNDING:	STATE: 0%
(PERCENT)	LOCAL: 0%
	PRIVATE: <u>0%</u>
	TOTAL: 100%

NOT RELEVANT TO THIS PROGRAM

PARTICIPANT PROFILE:	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	_____	_____	_____
% In-State Residents	_____	_____	_____
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

Maine

PROGRAM (Date Initiated): University of New England College of Osteopathic Medicine (NECOM) AHEC (1986)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: Shirley Weaver, Ph.D.
Director, AHEC Program
Address: University of New England College
of Osteopathic Medicine
11 Hills Beach Road
Biddeford, ME 04005
Telephone: 207-283-0171

TYPE OF INCENTIVE: AID IN PRACTICE: AHECs

NARRATIVE DESCRIPTION:

The NECOM AHEC program is currently in a planning stage, having received its first grant funds in October 1985. The program will be designed to focus on the issue of rural culture and comprehensive primary care health care. The AHEC will concentrate on the five northeastern counties in Maine, which account for one-half of the area in the state with a population of 300,000 which is widely dispersed and having 9 of 14 state-designated underserved areas. The area has a heavy concentration of rural persons for whom English is a second language, including Franco-Americans and Native Americans. The program will concentrate primarily on addressing the needs of these cultures, working almost exclusively with ambulatory rural health centers and their referral networks, and focus its early efforts on training health professions students, enhancing existing outreach to existing practitioners, and enhancing health manpower programming.

GOALS:

1. Improve the quality of primary health care to rural and ethnic populations in the northeast part of the state.
2. Attract physicians to rural areas.

PARTICIPATING INSTITUTIONS: Program still in planning stage.

CLINICAL SPECIALTIES: Program still in planning stage.

AREA SELECTION CRITERIA: HMSA

STANDARDS FOR FOR
PROGRAM EVALUATION:

OUTCOME:

Maine

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$ 0	\$ 0	\$ 0*

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	0%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	0%

* Beginning in October 1985, the AHEC has a two-year federal grant for \$150,000 per year.

NOT RELEVANT TO THIS PROGRAM

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #			
% In-State Residents			
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

MARYLAND
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
				X	X					

- X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

Maryland

PROGRAM (Date Initiated): Family Practice - Medical Scholarships (1972)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Douglas S. MacDonald, MD
Address: Maryland State Scholarship Board
2100 Guilford Avenue
Baltimore, MD 21218
Telephone: 301-659-6420

TYPE OF INCENTIVE: FINANCIAL INCENTIVES: Service Contingent Loans and Scholarships

NARRATIVE DESCRIPTION:

This state-funded program now awards two \$7,500 scholarships per year to state residents enrolled in the University of Maryland School of Medicine. Recipients must promise to practice general medicine for five years in an area of need.

Previously, the program awarded more scholarships of smaller amounts. However, the program reports that problems with buyouts led to a restructuring in 1985; the number of awards was decreased, and the amount of individual awards was increased.

- GOALS:**
1. Increase access to medical care in underserved urban/rural areas.
 2. Attract physicians to underserved urban/rural areas.

PARTICIPATING INSTITUTIONS: University of Maryland Medical School

ELIGIBILITY: 5-year Maryland resident; received Bachelor's degree; admitted to University of Maryland School of Medicine; financial need; committed to practice general medicine for 5 years in Maryland underserved area.

AREA SELECTION CRITERIA: HMSA Modification: HMSA, state or local public institution

Maryland

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$7,500	\$7,500	\$7,500	\$22,500	3
<u>SERVICE OBLIGATION</u>		<u>BUYOUT PROVISIONS</u>		
5 years in underserved area.		Repayment at 7% interest accruing from grant award		

STANDARDS FOR
PROGRAM EVALUATION: Placement in underserved areas.

OUTCOME: Because of problems with buyout, annual number of awards was reduced and amount increased from \$1,500 to \$7,500.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$</u>	<u>\$</u>	<u>\$</u>

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #			
% In-State Residents			
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

Maryland

PROGRAM (Date Initiated): Performance Loan (1966)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Michael Smith
Address: Maryland State Scholarship Board
2100 Guilford Avenue
Baltimore, Maryland 21218
Telephone: 301-659-6420

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES: Service-contingent Loans and Scholarships**

NARRATIVE DESCRIPTION:

The state of Maryland awards loans of up to \$7,500 to undergraduate medical and dental students who agree to practice in a specified area of the state upon completion of training. Students may fulfill their service obligation by practicing anywhere in Maryland except Montgomery County.

- GOALS:
1. Increase access to medical care in underserved rural areas.
 2. Reduce financial barriers to medical training for state residents.

PARTICIPATING INSTITUTIONS: Medical school, dental school

ELIGIBILITY: State resident, financial need

AREA SELECTION CRITERIA: Anywhere in the state except Montgomery County.

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$	\$7,500	\$7,500	\$30,000	4
<u>SERVICE OBLIGATION</u>			<u>BUYOUT PROVISIONS</u>	
One year for each year of support.			Principal + 10% interest, payable within 10 years.	

STANDARDS FOR
PROGRAM EVALUATION: Send letters to graduates to make sure they are practicing.

Maryland

OUTCOME:

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$</u>	<u>\$</u>	<u>\$</u>

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>		<u>1984</u>		<u>1985</u>	
	Phys.	Dent.	Phys.	Dent.	Phys.	Dent.
Total #	100	88	100	88	100	88
% In-State Residents	100	100	100	100	100	100
% Training/ Practicing in Rural Setting						
% Rural Origin						
% M/F						
% Minority						

Maryland

PROGRAM (Date Initiated): Worcester County Medical Scholarship (1960)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Reese Cropper, Jr.
Address: Advisory Board for Medical School of
Worcester County
P.O. Box 5
Berlin, MD 21811
Telephone: 301-641-1700

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES:** Service-contingent Loans and Scholarships

NARRATIVE DESCRIPTION:

This county-funded program provides scholarships to a small number of under-graduate medical students in return for a promise to practice medicine in the county after completion of residency training.

GOALS: 1. Attract physicians to underserved rural areas.

PARTICIPATING INSTITUTIONS: County Board of Commissioners, any accredited allopathic or osteopathic medical school.

ELIGIBILITY: Acceptance to allopathic or osteopathic school, commitment to practice in county.

AREA SELECTION CRITERIA: Other: Anywhere in the county.

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$5,000	\$5,000	\$5,000	\$20,000	4
<u>SERVICE OBLIGATION</u>			<u>BUYOUT PROVISIONS</u>	
1 year for each year of aid.			Principal + 20% penalty payable immediately.	

STANDARDS FOR
PROGRAM EVALUATION: Retention in Worcester County.

OUTCOME: The one physician who has completed the program is now serving in Worcester County.

Maryland

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$20,000	\$20,000	\$20,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	0%
LOCAL:	100%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	4	4	4
% In-State Residents	2	2	2
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female	75/25	75/25	75/25
% Minority	50	50	50

Maryland

PROGRAM (Date Initiated): Professional School Scholarships (1967)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Bertha M. Holbrook
Address: Maryland State Scholarship Board
2100 Guilford Avenue
Baltimore, MD 21218
Telephone: 301-659-6420

TYPE OF INCENTIVE: FINANCIAL INCENTIVES: Other Loans

NARRATIVE DESCRIPTION:

These state-funded Professional School Loans of \$200-\$1,000 per year are awarded to undergraduate medical and dental students. They will be used for tuition at specified institutions within the state of Maryland. Students have 10 years to repay the loans at a subsidized interest rate.

GOALS: 1. Reduce financial barriers to medical training for state residents.

PARTICIPATING INSTITUTIONS: Medical schools.

ELIGIBILITY: State resident, financial need.

AREA SELECTION CRITERIA:

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ None	\$1,000	\$1,000	\$4,000	4
<u>SERVICE OBLIGATION</u>			<u>BUYOUT PROVISIONS</u>	

STANDARDS FOR
PROGRAM EVALUATION:

OUTCOME:

<u>ANNUAL FUNDING LEVELS:</u>	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	\$150,000	\$150,000	\$150,000

Maryland

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 100%
LOCAL: 0%
PRIVATE: 0%
TOTAL: 100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	150	136	122
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

MASSACHUSETTS
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
X	X			X			X			X

X = Presence of program.
+ = Program added since 1981.
- = Program discontinued since 1981.

Massachusetts

PROGRAM (Date Initiated): Family Practice Residency Program/Community Practice Experience (1976)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Chris Micklitsch
Practice Management Coordinator
Address: Department of Family and Community Medicine,
University of Massachusetts Medical Center
55 Lake Avenue North
Worcester, MA 01605
Telephone: 617-856-5523

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Primary Care Residencies

NARRATIVE DESCRIPTION:

The Community Practice Experience (CPE) requires all third-year family practice residents from the University of Massachusetts Medical Center to affiliate for a one-month period with a private practice or health center of their choice. The rotation is expected to be both clinical and community oriented, with a high degree of involvement in the day-to-day activities of the host physician's or health center's practice. Additionally, it is hoped that the resident will become knowledgeable about assessing a practice, a community, and the general medical climate of a given area.

- GOALS:
1. Provide an opportunity to explore all facets of the health care system in a given community.
 2. Provide residents with the opportunity to explore the business functions of an active family practice.
 3. Encourage physicians to practice in areas of need.

PARTICIPATING INSTITUTIONS: Medical schools, graduate medical training program, practicing physicians.

CLINICAL SPECIALTIES: Family Practice

AREA SELECTION CRITERIA:

- STANDARDS FOR FOR
PROGRAM EVALUATION:
1. Preceptor evaluation of resident performance.
 2. Preceptor evaluation of overall program.
 3. Resident review of experience.

Massachusetts

OUTCOME:

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$ 0</u>	<u>\$ 0</u>	<u>\$ 0</u>

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	0%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	0%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	18	18	18
% In-State Residents	<u> </u>	<u> </u>	<u> </u>
% Training/ Practicing in Rural Setting	<u> </u>	<u> </u>	<u> </u>
% Rural Origin	<u> </u>	<u> </u>	<u> </u>
% Male/Female	<u> </u>	<u> </u>	<u> </u>
% Minority	<u> </u>	<u> </u>	<u> </u>

Massachusetts

PROGRAM (Date Initiated): New England Regional Contract Program (1955)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Carol Speer, Assistant Director
Address: New England Board of Higher Education
68 Walnut Road
Wenham, MA 01984
Telephone: 617-357-9620

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Seat Purchase

NARRATIVE DESCRIPTION:

This program is an agreement among the New England Board of Higher Education, the Commonwealth of Massachusetts, and Tufts and Boston University Medical Schools. The Board of Higher Education administers the program, in which the state pays the two medical schools a capitated rate to reserve places for financially needy Massachusetts residents. The goal of the program is to enable state residents to attend high-cost, competitive private medical schools to receive training not available at the state medical school. In return for the subsidy, students agree to practice within the state for six months for each year of subsidy.

- GOALS:
1. Retain state medical graduates within the state.
 2. Reduce financial barriers to medical training for state residents.
 3. Increase access to high-cost, competitive medical schools for state residents.

PARTICIPATING INSTITUTIONS: Medical schools, Board of Higher Education.

ELIGIBILITY: State resident, financial need, minority status, commitment to practice in the state.

AREA SELECTION CRITERIA: Anywhere in the state.

Massachusetts

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
Annual per capita amount	Annual per capita amount	\$10,200		4
<u>SERVICE OBLIGATION</u>		<u>BUYOUT PROVISIONS</u>		
6 months of service in the state per year of assistance.		Principal + current interest rate, payable within 10 years.		

STANDARDS FOR FOR
PROGRAM EVALUATION:

OUTCOME:

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$</u>	<u>\$</u>	<u>\$</u>

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #			
% In-State Residents			
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

Massachusetts

PROGRAM (Date Initiated): Massachusetts Learning Contract Program (1978)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Robert E. Tranquada, M.D., Chancellor
Address: Massachusetts Learning Contract Program
University of Massachusetts Medical Center
55 Lake Avenue North
Worcester, MA 01605
Telephone: 617-856-2265

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES: Service-contingent Loans and Scholarships**

NARRATIVE DESCRIPTION:

This program defers two-thirds of tuition for all students entering the University of Massachusetts Medical School who sign a contract stating that they will serve in the Commonwealth after completing their training or pay back the deferred tuition within 10 years. The program is designed to assist state residents in financing their medical school education, and to encourage graduates to practice in the state.

- GOALS:
1. Retain state medical graduates within the state.
 2. Reduce financial barriers to medical training for state residents.

PARTICIPATING INSTITUTIONS: University of Massachusetts Medical School.

ELIGIBILITY: State resident, commitment to practice in the state, acceptance to University of Massachusetts Medical School.

AREA SELECTION CRITERIA: Anywhere in the state.

Massachusetts

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
	2/3 tuition	2/3 tuition		4
<u>SERVICE OBLIGATION</u>		<u>BUYOUT PROVISIONS</u>		
One year of service in the Commonwealth for each year of deferral		No penalty. 10-year payback period.		

STANDARDS FOR FOR
PROGRAM EVALUATION: Number of participants remaining in state.

OUTCOME: No class that has yet graduated and completed residencies;
therefore, it is too early for outcomes.

<u>ANNUAL FUNDING LEVELS:</u>	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	0*	0*	0*

* University of Massachusetts tuition goes directly into the state's general
fund; therefore, there is no explicit funding for this program.

CURRENT SOURCE OF FUNDING: (PERCENT)	FEDERAL: 0%
	STATE: 0%
	LOCAL: 0%
	PRIVATE: 0%
	TOTAL: 0%

<u>PARTICIPANT PROFILE:</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	400	400	400
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

Massachusetts

PROGRAM (Date Initiated): Manpower Linkage and Support Project (1978)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Chris Micklitsch
Practice Management Coordinator
Address: Department of Family and Community Medicine,
University of Massachusetts Medical Center
55 Lake Avenue North
Worcester, MA 01605
Telephone: 617-856-5523

TYPE OF INCENTIVE: AID IN PRACTICE: Placement

NARRATIVE DESCRIPTION:

The Manpower Linkage and Support Project focuses its efforts primarily on publishing a quarterly bulletin entitled Practice Opportunities Bulletin. The bulletin is a mechanism for matching practicing physicians and communities in need. The bulletin focuses on primary care specialties and opportunities in underserved parts of the state as identified through the Massachusetts State-wide AHEC. The Manpower Linkage and Support Project coordinates its efforts with the Massachusetts Statewide AHEC.

GOALS:

1. Facilitate communication between physicians and communities in need.
2. Attract physicians to underserved areas.
3. Retain state medical graduates within the state.

PARTICIPATING INSTITUTIONS: Medical schools, graduate medical training programs, AHECs, practicing physicians.

CLINICAL SPECIALTIES: Primary care.

AREA SELECTION CRITERIA: Anywhere in the state.

STANDARDS FOR FOR
PROGRAM EVALUATION:

OUTCOME: Circulation of bulletin is 800.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$ 0</u>	<u>\$ 0</u>	<u>\$ 0</u>

Massachusetts

CURRENT SOURCE	FEDERAL:	0%
OF FUNDING:	STATE:	0%
(PERCENT)	LOCAL:	0%
	PRIVATE:	0%
	TOTAL:	0%

NOT RELEVANT TO THIS PROGRAM

PARTICIPANT PROFILE:	1983	1984	1985
Total #			
% In-State Residents			
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

Massachusetts

PROGRAM (Date Initiated): Massachusetts Statewide AHEC (1978)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Michael E. Huppert, Director,
Address: Massachusetts Statewide AHEC
 University of Massachusetts Medical Center
 55 Lake Avenue North
 Worcester, MA 01605
Telephone: 617-856-3255

TYPE OF INCENTIVE: **AID IN PRACTICE: AHECs**

NARRATIVE DESCRIPTION:

Massachusetts statewide AHEC educates medical students in the community, promotes primary care, prepares professionals to practice in underserved areas, supports nursing and allied health education, develops minority recruitment programs, implements interdisciplinary educational and professional experiences for health providers, and prepares health professionals to educate their patients regarding their own health:

- For undergraduate medical students, AHEC sponsors off-campus community rotations. In addition to helping negotiate and plan for these practice opportunities, AHEC provides subsidies for travel and/or housing to those students electing these off-campus experiences.
- AHEC also supports residencies in primary care -- family medicine, internal medicine, pediatrics and obstetrics/gynecology -- in community hospitals and in rural and inner city areas. Its support includes program directors and faculty, development of teaching clinics, expansion of training, faculty consultants, conferences, and educational videotapes.
- AHEC also supports dentistry, through a preceptorship program in Boston, support of a residency program in general practice dentistry, and continuing education.
- The AHEC sponsors minority recruitment activities at the University of Massachusetts Medical Center and other parts of the state. The AHEC also focuses on nursing and allied health manpower and education through a variety of initiatives.
- For practicing health professionals, the six AHEC sites provide Continuing Medical Education programs.

GOALS:

1. Increase access and quality of care in underserved areas.
2. Balance physician supply with demand.
3. Retain state medical graduates within the state.

Massachusetts

PARTICIPATING INSTITUTIONS: Medical schools, graduate medical training programs, hospitals, practicing physicians, AHEC sites.

CLINICAL SPECIALTIES: Primary care.

AREA SELECTION CRITERIA: HMSA

STANDARDS FOR FOR PROGRAM EVALUATION: Quality of and access to care in underserved areas.

OUTCOME: None formal.

ANNUAL FUNDING LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$2,632,875	\$2,439,232	\$2,585,005

CURRENT SOURCE OF FUNDING: (PERCENT)

FEDERAL:	49%
STATE:	51%*
LOCAL:	*%
PRIVATE:	0%
TOTAL:	100%

* 51 percent consists of state and local funds, grants and contracts.

PARTICIPANT** PROFILE (CME):

	<u>1983</u>	<u>1984</u>	<u>1985</u>
<u>Total #</u>			
Medicine	2,627	3,230	924
Dentistry	1,193	765	1,080
Nursing	28,585	22,182	16,431
Allied	14,869	14,442	20,884
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

** Number of continuing education contact hours statewide.

MICHIGAN
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
X		X		-			X			

X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

- 163 -

Michigan

Michigan

PROGRAM (Date Initiated : Family Practice Residency Program (1975)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Russell E. Holmes, M.D., MPH
Medical Consultant
Address: Michigan Department of Public Health
P.O. Box 30035
3500 W. Logan
Lansing, MI 48909
Telephone: 517-373-1356

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Primary Care Residencies

NARRATIVE DESCRIPTION:

This program provides subsidies to family practice residency programs through project grants targeted particularly to those which serve urban poverty areas or medically underserved areas, and those which actively recruit minority and women physicians. In the current fiscal year the program is funding six programs: four in Detroit, one in Pontiac and one in Midland. One of the Detroit residencies includes a rural rotation.

The program has lost legislative support in recent years. Annual funding levels have declined from the original amount of \$1 million annually to the current \$100,000. There is no funding for the program in the FY 1987 budget, so it is likely that the program will phase out after the current cycle of grants run out in early 1987.

GOALS:

1. Increase access to medical care in underserved urban areas .
2. Encourage development of both under-graduate and graduate educational experience in medically underserved areas.
3. Promote medical career opportunities for the economically disadvantaged and minority groups.

PARTICIPATING INSTITUTIONS: Accredited family practice residency programs, group practice, private practice

CLINICAL SPECIALTIES:

AREA SELECTION CRITERIA:

Michigan

STANDARDS FOR

PROGRAM EVALUATION:

Proportion of graduates choosing primary care specialties

OUTCOME: 63 percent remained in state; 31 percent in area with population of fewer than 10,000.

ANNUAL FUNDING
LEVELS:

FY 1983

FY 1984

FY 1985

\$100,000

\$100,000

\$ 100,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 100%
LOCAL: 0%
PRIVATE: 0%
TOTAL: 100%

PARTICIPANT
PROFILE:

1983

1984

1985

Total #

% In-State
Residents

% Training/
Practicing in
Rural Setting

% Rural Origin

% Male/Female

% Minority

Michigan

PROGRAM (Date Initiated): Preceptorships and Junior Partnership Program (1969)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Margot Kurtz Ph.D. Director
Address: Department of Family Medicine
College of Osteopathic Medicine
West Fee Hall
Michigan State University
East Lansing, MI 48824
Telephone: 517-353-4730

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Preceptorships

NARRATIVE DESCRIPTION:

The preceptorship and Junior Partnership implement Michigan State University College of Osteopathic Medicine's philosophy of early and continuous clinical exposure. These clinical experiences are intended to provide students with a realistic view of what it means to be a family physician. All students are required to rotate through four preceptorship experiences in year two, spending one afternoon per week in each of four terms. The Junior Partnership is a required full-time, six-week rotation with a family physician, and taken in year three or four. Students are evaluated by their preceptors and senior partners and must also complete prescribed evaluations of their supervising physician. Preceptors and senior partners serve voluntarily, without compensation.

GOALS:

1. Provide students with practical experience in all aspects of health care with emphasis on exposure to realistic role models of family physicians.
2. Increase the number of physician in family physicians.
3. Achieve a balance of physician supply with projected need or demand.

PARTICIPATING INSTITUTIONS: Medical school, ambulatory care facility, group practice, private practice

CLINICAL SPECIALTIES: Family medicine, primary care

AREA SELECTION CRITERIA:

Michigan

STANDARDS FOR
PROGRAM EVALUATION: Proportion of graduates choosing primary care
specialties

OUTCOME:

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$20,000	\$20,000	\$20,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	45	45	45
% In-State Residents			
% Training/ Practicing in Rural Setting	33	33	33
% Rural Origin			
% Male/Female			
% Minority			

Michigan

PROGRAM (Date Initiated): Upper Peninsula Medical Education Program (1974)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: Jack Van Tassel, President
Address: Upper Peninsula Health Education Corp.
540 West Kaye Avenue
P.O. Box 7007
Marquette, MI 49855
Telephone: 906-228-7970

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Preceptorships

NARRATIVE DESCRIPTION:

The Upper Peninsula Medical Education Corporation (UPHEC) administers a branch campus of Michigan State University's College of Human Medicine -- the only branch located in a rural, medically underserved area. The program provides predoctoral clinical education in primary care for a selected group of undergraduate medical students. UPHEC conducts jointly with MSU a regionalized system of primary/ambulatory care and also established a family practice residency program in 1978.

UPHEC reports that the undergraduate and graduate medical education programs have effected significant improvements in accessibility and quality of medical care in the region both by increasing the numbers of physicians entering practice and by involving community physicians in the educational program.

- GOALS:**
1. Attract physicians to underserved rural areas.
 2. Increase access to medical care in underserved rural areas .
 3. Increase the number of physicians in family practice.

PARTICIPATING INSTITUTIONS: Medical school, FME program, hospital, ambulatory care facility.

CLINICAL SPECIALTIES: Family practice

AREA SELECTION CRITERIA:

STANDARDS FOR PROGRAM EVALUATION: Proportion of program participants who go into primary care, and proportion who practice in Upper Peninsula

Michigan

OUTCOME: Over 70% of participants now in practice are in primary care; about 25% of undergraduate participants and about 50% of those who complete the residency program eventually practice in the Upper Peninsula.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	\$1,934,977	\$1,269,388

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	60%
LOCAL:	0%
PRIVATE:	40%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #			27
% In-State Residents	50	50	50
% Training/Practicing in Rural Setting	100	100	100
% Rural Origin			
% Male/Female			
% Minority			

Michigan

PROGRAM (Date Initiated : Physician Placement Service, Michigan Health Council (1953)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: James Tarrant, President
Address: Michigan Health Council
1305 Abbott Road, #106
East Lansing, MI 48223
Telephone: 517-377-1615

TYPE OF INCENTIVE: **AID IN PRACTICE: Placement**

NARRATIVE DESCRIPTION:

The Physician Placement Service assists physicians to locate in Michigan communities, generally in less populous, medically underserved areas. Since its inception in 1953, the service has helped place over 2,100 physicians. The service is utilized by hospitals, communities, clinics, HMOs and other alternative health care delivery systems, and established physician practices, as well as by the physicians who register with the Council. A Roster of Opportunities, published annually, is sent to registrants of the Placement Service as are periodic supplements. Two conferences per year are held for senior residents and practicing physicians seeking practice locations. Consultation services are available to Michigan communities to assist them in organizing recruitment committees and in measuring the effectiveness of such committees. Nominal fees are charged for these services, but more specialized referral and counseling services are available for an additional fee, including site visits by Council staff.

GOALS:

1. Increase number of primary care or family practice physicians.
2. Retain medical graduates within the state.
3. Attract physicians to underserved urban rural areas.

PARTICIPATING INSTITUTIONS: Hospitals, graduate medical educational programs, clinics, local medical specialty groups and other alternative health care delivery systems.

CLINICAL SPECIALTIES: All

AREA SELECTION CRITERIA:

Michigan

STANDARDS FOR
PROGRAM EVALUATION:

Numbers of physicians placed in communities seeking them.

OUTCOME: Placed about 50 per year (over 2100 since inception of program in 1953).

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$36,500	\$41,600	\$74,800

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 0%
LOCAL: 0%
PRIVATE: 100%
TOTAL: 100%

NOT RELEVANT TO THIS PROGRAM

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #			
% In-State Residents			
% Training/Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

Michigan

PROGRAM (Date Initiated): Michigan Council for Graduate Medical Education
(1982)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: Charles Manninen, Executive Director

Address: Michigan Hospital Association

6215 West St. Joseph Highway

Lansing, MI 48917

Telephone: 517-323-3443

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Planning Body

NARRATIVE DESCRIPTION:

The Council, composed of representatives of the major organizations involved in medical and osteopathic medical education in Michigan, is a voluntary planning body for graduate medical education (GME). The Council develops goals for the numbers and specialty mix of residencies and other post-graduate medical training programs in the state. Through its annual survey of GME programs, the Council collects and disseminates information about numbers of residencies offered and filled, distribution of residents by place of training, (U.S. and foreign trained), numbers of graduates and numbers retained in the state. An important function of the Council is to advise the Statewide Health Coordinating Council about the physician distribution issues and other policy issues affected by or impinging on GME.

GOALS:

1. Achieve balance of physician supply with projected need or demand.
2. Increase the number of physicians in family practice and primary care.
3. Keep state government advised of developments in GME.

PARTICIPATING INSTITUTIONS: State medical and osteopathic medical societies, state hospital associations, allopathic and osteopathic.

CLINICAL SPECIALTIES: All

AREA SELECTION CRITERIA:

STANDARDS FOR

PROGRAM EVALUATION: Distribution of GME positions by specialty and numbers completing residencies in various specialty areas.

Michigan

OUTCOME:

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$</u>	<u>\$</u>	<u>\$</u>

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 0%
LOCAL: 0%
PRIVATE: 100%
TOTAL: 100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #			27
% In-State Residents	50	50	50
% Training/ Practicing in Rural Setting	100	100	100
% Rural Origin			
% Male/Female			
% Minority			

MINNESOTA
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
	-	X								

X = Presence of program.
+ = Program added since 1981.
- = Program discontinued since 1981.

Minnesota

PROGRAM (Date Initiated): Rural Physician Associate Program (1971)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: John Verby, MD, Director
Address: Department of Family Practice and Community
Medicine
University of Minnesota Medical School
Box 81 Mayo
420 Delaware Street, S.E.
Minneapolis, MN 55455
Telephone: 612-376-3111

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Preceptorship

NARRATIVE DESCRIPTION:

The Rural Physician Associate Program, sponsored by the University of Minnesota Medical School and supported by state funds, places third-year undergraduate medical students for 9-12 months in rural areas. Students assist a community primary care physician in his or her practice. Students also participate in monthly seminars by visiting specialists, read about clinical problems they have observed, are audiovisually taped while performing patient interviews, participate in family therapy sessions, access medical databases through a microcomputer telecommunications network, and write a paper about their experience. The objective of the program is to encourage graduates to locate in rural areas of Minnesota.

GOALS:

1. Promote the redistribution of physicians to underserved rural areas of Minnesota.
2. Improve quality of and access to medical care in underserved rural areas of Minnesota.
3. Provide a high-quality, long-term rural preceptorship experience for undergraduate medical students.

PARTICIPATING INSTITUTIONS: University of Minnesota Medical School, rural community physicians.

CLINICAL SPECIALTIES: Family practice, community medicine.

AREA SELECTION CRITERIA: Other: Rural

STANDARDS FOR PROGRAM EVALUATION: Retention in rural areas in Minnesota.

Minnesota

OUTCOME: Of 295 participants in medical practice:
 110 (37%) in rural Minnesota.
 61 (21%) in rural other states.
 75 (25%) in metropolitan Minnesota.
 49 (17%) in metropolitan other states.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$405,000	\$415,000	\$425,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	29	19	24
% In-State Residents	93	100	92
% Training/Practicing in Rural Setting	0	0	24
% Rural Origin	45	68	58
% Male/Female	79/21	74/26	67/33
% Minority	0	0	8

Minnesota

PROGRAM (Date Initiated): Family Practice Preceptorship (1972)

ADMINISTRATIVE LOCUS: Medical school

ADMINISTRATOR:

Director/Contact Person: James Boulger
Address: School of Medicine - University of Minnesota -
Duluth
2400 Oakland Avenue
Duluth, MN 55812
Telephone: 218-726-8999

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Preceptorships

NARRATIVE DESCRIPTION:

The University of Minnesota School of Medicine at Duluth was established in an effort to alleviate geographic and specialty maldistribution of physicians in Minnesota since previous medical education was concentrated in Minneapolis. Upon successful completion of their first two years of medical school in Duluth, undergraduate students are accepted on a noncompetitive basis into the medical school at University of Minnesota in Minneapolis. Emphasis within the curriculum at Duluth is on family practice, particularly on practice in smaller rural communities. Faculty have been appointed with this goal in mind. Reinforcement of student interest in family practice is achieved through exposure to family practice through preceptorships in both the first and second years of medical school. During the first year, each student is assigned to a practicing family physician in the Duluth/Superior/Cloquet area. During the second year, each student is assigned to a family physician preceptor in a smaller community; the student meets with the preceptor for a period of three consecutive days (and nights) mid-way through each academic quarter.

GOALS:

1. Increase access to medical care in underserved rural areas.
2. Attract physicians to underserved rural areas.
3. Increase the number of physicians in primary care.

PARTICIPATING INSTITUTIONS:

CLINICAL SPECIALTIES: Family practice

AREA SELECTION CRITERIA:

STANDARDS FOR

PROGRAM EVALUATION: Number of students selecting family practice residencies and entering family practice in small communities.

Minnesota

OUTCOME: Of most students who have completed training and entered residencies, 56 percent have selected training in family practice residencies. Seventy percent of those completing residencies and entering practice have selected practice sites in communities of fewer than 20,000.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$</u>	<u>\$</u>	<u>\$</u>

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 100%
LOCAL: 0%
PRIVATE: 0%
TOTAL: 100%

PARTICIPANT
PROFILE:

<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #		48
% In-State Residents		
% Training/Practicing in Rural Setting		
% Rural Origin		
% Male/Female		
% Minority		

MISSISSIPPI
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
				X						

X = Presence of program.
+ = Program added since 1981.
- = Program discontinued since 1981.

Mississippi

PROGRAM (Date Initiated): Mississippi Medical Education Loan Program
(1975)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Marla Harrison, Student Counselor
Address: Institute of Higher Learning
P. O. Box 2336
Jackson, MS 39205
Telephone: 601-982-6611

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES: Service-contingent Loans and Scholarships**

NARRATIVE DESCRIPTION:

The Institute of Higher Learning, Mississippi's state higher education authority, offers loans annually to undergraduate medical and dental students who agree to practice in an area of the state with a 1980 population of fewer than 10,000 or in a state mental institution, a state charity hospital, or in the field of public health. Physicians also must agree to practice in internal medicine, family medicine, ob/gyn, or pediatrics.

The program was modified in 1983 due to state budget constraints to limit participants to those attending the University of Mississippi Medical Center.

- GOALS:
1. Attract physicians and dentists to underserved areas.
 2. Increase the number of physicians in primary care.
 3. Retain state medical graduates and dentists within the state.

PARTICIPATING INSTITUTIONS: University of Mississippi Medical Center.

ELIGIBILITY: State resident, financial need, commitment to practice in shortage area, commitment to practice in the state, attend University of Mississippi Medical Center.

AREA SELECTION CRITERIA: Community size: 1980 population of fewer than 10,000

Mississippi

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ None	\$ 6,000	\$6,000	\$24,000	4
<u>SERVICE OBLIGATION</u>		<u>BUYOUT PROVISIONS</u>		
Five years in state public health for 100% forgiveness; one-fifth forgiveness for one year of practice in an area with population fewer than 10,000.		150% of Principal + 6% interest payable within 4-5 years. \$5,000 penalty for failure to complete 5 years' service.		

STANDARDS FOR FOR
PROGRAM EVALUATION:

OUTCOME:

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$130,000- 150,000	\$130,000- 150,000	\$130,000- 150,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	60	60	60
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female	75/25	75/25	75/25
% Minority	33	33	33

MISSOURI
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
				X						

X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

Missouri

PROGRAM (Date Initiated): Missouri Loan Program for Medical and Osteopathic Students (1978)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: George Thomas, Director
Address: Section of Local Health Services
Missouri Department of Health
P. O. Box 570
Jefferson City, MO 65102
Telephone: 314-751-2017

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES:** Service-contingent Loans and Scholarships

NARRATIVE DESCRIPTION:

The Missouri legislature authorized this program to provide financial assistance to state residents attending medical or osteopathic school. The program's objective is to increase the number of practitioners in rural areas of the state. Students receive up to 4 years of assistance in return for an agreement to practice in an area with a population of fewer than 6,000, or any unincorporated area of the state not included in a MSA. For each year of practice in an eligible site, 25 percent of the loan amount is forgiven.

Although most areas of the state qualify as eligible practice sites, the program reports that only half the graduates practice in rural areas; many choose to remain in Kansas City or other urban areas. The program is currently attempting to improve outcomes by more frequent contacts and communications with participants. Due to budgetary constraints, the program budget has declined since 1981.

- GOALS:
1. Attract physicians to rural areas.
 2. Retain state medical students within the state.
 3. Reduce financial barriers for state residents attending medical or osteopathic school.

PARTICIPATING INSTITUTIONS: Medical schools, osteopathic schools.

ELIGIBILITY: State resident for at least one year in non-academic setting, financial need, attending medical or osteopathic school in Missouri, commitment to practice in state.

Missouri

AREA SELECTION CRITERIA: Community size: fewer than 6,000 or any area not included in a Metropolitan Statistical Area.

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ None	\$6,000	\$6,000	\$ None	4

SERVICE OBLIGATION

One year of service in designated area for 25% forgiveness. 100% forgiveness in 4 years.

BUYOUT PROVISIONS

Principal + 9% interest, payable within one year.

STANDARDS FOR FOR PROGRAM EVALUATION: Percent of participants fulfilling service obligation.

OUTCOME: 59 percent currently fulfill their service obligations.

ANNUAL FUNDING LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$80,000	\$50,000	\$50,000

CURRENT SOURCE OF FUNDING: (PERCENT)

FEDERAL: 0%
STATE: 100%
LOCAL: 0%
PRIVATE: 0%
TOTAL: 100%

PARTICIPANT PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	8	8	8
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	70	65	59
% Rural Origin	50	50	50
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

MONTANA
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
	X									

X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

Montana

PROGRAM (Date Initiated): Washington, Alaska, Montana, Idaho (WAMI)
Regional Program (1971)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Stephen J. Guggenheim, M.D.
Coordinator, WAMI Program
Address: Montana State University
Johnson Hall
Bozeman, MT 59717
Telephone: 406-944-4411

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Seat Purchase

NARRATIVE DESCRIPTION:

WAMI is a program in Washington, Alaska, Montana and Idaho whose purpose is to guarantee access to medical school to qualified students from the four states and is designed to expose students to medical practice outside of metropolitan areas. Students from the participating states enroll at the University of Washington School of Medicine, the only public medical school in the four states, but take basic science courses on their "home" campuses (e.g., University of Montana) for the first year. After the first year, they move to the Seattle Campus. In the third and fourth years, students may elect to take six weeks of primary care clinical training with community physicians in three different locations in Montana. Physicians providing clerkship training are appointed to the School of Medicine faculty, allowing them continuing educational opportunities there.

- GOALS:
1. Make medical education accessible to Montana residents.
 2. Increase access to medical care in underserved urban and rural areas.
 3. Attract physicians to underserved urban and rural areas.
 4. Increase the number of physicians in primary care and/or family practice.
 5. Keep costs as low as possible.

PARTICIPATING INSTITUTIONS: Medical schools, graduate medical training programs, colleges, hospitals, ambulatory care facilities, group practice, private practice.

CLINICAL SPECIALTIES:

Montana

AREA SELECTION CRITERIA:

STANDARDS FOR

PROGRAM EVALUATION: Proportion of physicians who return to practice in the state and proportion engaged in primary care.

OUTCOME: 1985 - 37% of graduates who have completed training are now practicing in state.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$2,132,847	\$2,254,832	\$2,374,157

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	80	80	80
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female	55/25	55/25	50/30
% Minority	0	0	1

NEBRASKA
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
-				X						

X = Presence of program.
+ = Program added since 1981.
- = Program discontinued since 1981.

Nebraska

Nebraska

PROGRAM (Date Initiated): Nebraska Medical Student Loan Program (1978)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: David Montgomery, Administrator
Address: Rural Health Manpower Commission
Nebraska Department of Health
P.O. Box 95007
Lincoln, NE 68509
Telephone: 402-471-2337

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES:** Service-contingent Loans and Scholarships

NARRATIVE DESCRIPTION:

The Nebraska Medical Student Loan Program provides low interest, long-term loans to support the medical education of Nebraska residents. In return for the loan, students agree to practice primary care medicine in a medically underserved area of Nebraska. Students must still repay the loan, but at a lower interest rate and at a later time than students who fail to fulfill the service requirement. Students are selected for participation in the program by the Rural Health Manpower Commission. Selection is based largely on the Commission's judgment of the student's likelihood of remaining in a rural practice in Nebraska. Evidence of a life history in rural Nebraska and other present and future ties to such areas are weighted heavily in the determination.

GOALS:

1. Reduce financial barriers to medical training for state residents.
2. Attract physicians to underserved rural areas.
3. Increase access to medical care to underserved rural areas.

PARTICIPATING INSTITUTIONS: Medical schools in Nebraska.

ELIGIBILITY: State resident, commitment to practice in medically underserved or shortage area, commitment to primary care, acceptance into a Nebraska medical school.

AREA SELECTION CRITERIA: HMSA

Nebraska

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ No minimum	\$ 7,000	\$ 7,000	\$28,000	4

SERVICE OBLIGATION

One year of practice in a medical profession shortage area for each year of loan, with repayment at 5% interest rate if service is completed commencing upon completion of service, and made over a period of 3 years for each year of loan.

BUYOUT PROVISIONS

Principal + market interest rates accruing from the award date. The repayment period is negotiated on a case-by-case basis.

STANDARDS FOR
PROGRAM EVALUATION:

The number of physicians who complete service requirement; the number of physicians who remain in the shortage area after the service obligation. Ultimately the latter measure will be used for program evaluation.

OUTCOME: The first physicians to serve began in 1984. The first two years of outcome data indicate an 84% obligation fulfillment rate.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$260,000	\$280,000	\$231,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 100%
LOCAL: 0%
PRIVATE: 0%
TOTAL: 100%

PARTICIPANT PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	40	34	34
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting			
% Rural Origin	68	85	88
% Male/Female	85/15	85/15	85/15
% Minority	2.5	5.9	2.9

NEVADA

STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
							-	X		

- X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

Nevada

PROGRAM (Date Initiated): Central Nevada Rural Health Consortium (1977)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Max Chilcott, Acting Executive Director
Address: Central Nevada Rural Health Consortium
P. O. Box 225
Babbit, NV 89416
Telephone: 702-945-3381

TYPE OF INCENTIVE: FINANCIAL INCENTIVES: Guaranteed Income

NARRATIVE DESCRIPTION:

The Central Nevada Rural Health Consortium is designed to meet the needs of five rural counties in Nevada by recruiting providers, staffing the clinics, and covering operational costs including salaries until the decentralized clinic sites become self-sufficient. A program of community outreach, in-service training, and health education complement the primary medical care provided to the local residents and insures appropriate utilization of health care resources. The program develops marketing strategies to encourage individuals to use the providers in the community. Recognizing that these counties have a minimal tax base and that many services cannot be supported by one county alone, the Consortium relies on shared services and linkages with secondary and tertiary facilities, as well as state and local health agencies to provide resources to support its eight clinics.

GOALS:

1. Provide primary care in rural areas.
2. Increase access to medical care in underserved rural areas.
3. Attract physicians to underserved rural areas.

PARTICIPATING INSTITUTIONS: Ambulatory care facilities.

ELIGIBILITY: Provider must have a Nevada license.

AREA SELECTION CRITERIA: HMSA or MUA.

Nevada

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$No minimum	\$50,000 physician salary; \$30,000 physician assistant plus \$1,000 per month for sponsoring physician	\$50,000 physician; \$30,000 physician assistant	None specified	No maximum
<u>SERVICE OBLIGATION</u>		<u>BUYOUT PROVISIONS</u>		

STANDARDS FOR

PROGRAM EVALUATION:

The number of physicians who remain in the area. The number of sites that become self-sufficient.

OUTCOME: Over the life of the program, 1 physician out of 14 remained at the site. All the physician's assistants remained. One site became self-sufficient.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$1,000,000	\$1,000,000	\$1,000,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	50%
STATE:	0%
LOCAL:	50%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT PROFILE:

	<u>1983</u>		<u>1984</u>		<u>1985</u>	
	<u>MD</u>	<u>PA</u>	<u>MD</u>	<u>PA</u>	<u>MD</u>	<u>PA</u>
Total #	3	5	4	5	2	6
% In-State Residents	0	0	0	0	0	0
% Training/Practicing in Rural Setting	100		100		100	
% Rural Origin	0	1	0	1	1	2
% Male/Female	100/0	100/0	100/0	100/0	100/0	100/0
% Minority	100/0	0	0	0	0	0

NEW HAMPSHIRE
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
		X								

X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

New Hampshire

PROGRAM (Date Initiated): Primary Care/Family Medicine Preceptorships
(1974)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: Suzanne Reed, Coordinator
Address: Department of Community and Family Medicine
Dartmouth Medical School
Hanover, NH 03755
Telephone: 603-646-7480

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Preceptorships

NARRATIVE DESCRIPTION:

Dartmouth Medical School offers an elective preceptorship in Primary Care/Family Medicine to its first and second year undergraduate medical students. Students spend two days per month with a family physician located in the general area. Approximately one-third of students in each class participate in the program. The first-year students are also required to take a clinical symposium, in which they are assigned to a local physician and spend time with that physician in the office and hospital. Finally, fourth-year students do a primary care clerkship for 6 weeks on a full-time basis. The purpose of these preceptorships is to expose students to family practice and community medicine.

GOALS:

1. Expose medical students to family and community medicine.
2. Expose medical students to clinical practice.

PARTICIPATING INSTITUTIONS: Medical school, practicing physicians.

CLINICAL SPECIALTIES: Family practice, primary care

AREA SELECTION CRITERIA:

STANDARDS FOR FOR
PROGRAM EVALUATION: Student and preceptor satisfaction as measured by
evaluation forms.

OUTCOME: Both students and preceptors appreciate the value of the
experience.

New Hampshire

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$ *</u>	<u>\$ *</u>	<u>\$ *</u>

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	0%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	0%

* These programs are funded as part of Dartmouth's general educational budget.

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	240**	240**	240**
% In-State Residents	_____	_____	_____
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

** There are 240 students at Dartmouth Medical School.

NEW JERSEY
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
X				-						

X = Presence of program.
+ = Program added since 1981.
- = Program discontinued since 1981.

- 197 -

New Jersey

New Jersey

PROGRAM (Date Initiated): Graduate Medical Education Program of New Jersey (GMEP) (1977)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Sarah Kleinman, MPH, Program Officer
Graduate Medical Education Program
Address: New Jersey Department of Higher Education
225 West State Street
Trenton, NJ 08625
Telephone: 609-292-7171

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Primary Care Residencies

NARRATIVE DESCRIPTION:

The state-funded Graduate Medical Education Program (GMEP) was established to provide seed money in the form of competitive grants to encourage the development of new or enhancement of existing graduate medical education programs as deemed necessary to meet the physician needs of the state. Currently, the program is focusing on geriatrics and psychiatric care. Programs applying for grants must demonstrate the need in their area for physician manpower, mechanisms for retention of program trainees within the state and a long-term commitment on the part of some outside funding source to maintain the program. The GMEP currently funds approximately 20 programs, which address pediatrics ob/gyn, family medicine, general internal medicine, geriatrics, and psychiatry.

GOALS:

1. Achieve a balance of physician and dentist supply with projected demand.
2. Increase the number of physicians in primary care.

PARTICIPATING INSTITUTIONS: Medical schools, graduate medical training programs.

CLINICAL SPECIALTIES: Primary care.

AREA SELECTION CRITERIA:

STANDARDS FOR FOR
PROGRAM EVALUATION: Physician manpower in the state.

OUTCOME: Have seen improvement over the life of the program.

New Jersey

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$365,000	\$365,000	\$350,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	20 programs	20 programs	20 programs
% In-State Residents	_____	_____	_____
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

NEW MEXICO
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
		X	X	X			X		+	

X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

New Mexico

PROGRAM (Date Initiated): Primary Care Curriculum, UNM School of Medicine (1979)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Elizabeth Baca, Program Specialist
Address: University of New Mexico School of Medicine
P. O. Box 523
Albuquerque, NM 87131
Telephone: 505-277-2457

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Other Curriculum Changes

NARRATIVE DESCRIPTION:

The Primary Care Curriculum (PCC) is a two-year program covering years one and two of medical school. Twenty students are admitted per year. The curriculum relies heavily upon problem-based, student-centered learning in a small group tutorial format. Students receive extensive clinical training in the first year, in addition to the traditional basic sciences. During both the first and second year, students actually practice with a primary care physician in a non-urban area. The PCC is separate from the regular undergraduate medical curriculum.

GOALS:

1. Attract physicians to underserved urban and rural areas.
2. Offer alternative educational experience for undergraduate medical students centered on problem-based learning.

PARTICIPATING INSTITUTIONS: Medical school, hospitals, ambulatory care facilities, group and private practice.

CLINICAL SPECIALTIES: Primary care.

AREA SELECTION CRITERIA:

**STANDARDS FOR
PROGRAM EVALUATION:**

OUTCOME: Of the 10 1984 graduates, 7 chose primary care residencies -- 5 in family practice, and 1 each in internal medicine and pediatrics. In 1985, 9 of 16 graduates entered primary care residencies -- 5 in family practice, 3 in internal medicine, and 1 in pediatrics.

New Mexico

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$362,000	\$358,000	\$383,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	66-2/3%
LOCAL:	0%
PRIVATE:	33-1/3%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	40	40	40
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

New Mexico

PROGRAM (Date Initiated): Preceptorship Program, UNM School of Medicine (1973)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Aleksandra Counsellor, M.S., Program Coordinator
Address: University of New Mexico School of Medicine
Department of Family, Community and Emergency
Medicine
Albuquerque, NM 87131
Telephone: 505-277-3510

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Preceptorship

NARRATIVE DESCRIPTION:

All fourth-year medical students at UNM School of Medicine are required to serve a one-month preceptorship in a rural community with an approved preceptor. Each student selects a site in New Mexico in which to work with a physician and interrelate in a community. The program enables the student to see the advantages and disadvantages of life and work in a small rural community. The student can evaluate the clinical aspects of his/her role model's work as well as other aspects of the physician's life in such communities.

- GOALS:
1. Increase number of physicians in primary care.
 2. Attract physicians to underserved rural areas.
 3. Retain medical graduates within the state.

PARTICIPATING INSTITUTIONS: Medical school, hospital, ambulatory care facility, group practice, private practice

CLINICAL SPECIALTIES: Family practice (predominantly).

AREA SELECTION CRITERIA:

STANDARDS FOR
PROGRAM EVALUATION:

OUTCOME: Over half of the 1981 graduates entered primary care residencies.
Of 1985 graduates, 74% entered primary care residencies.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$12,300</u>	<u>\$12,300</u>	<u>\$12,300</u>

New Mexico

CURRENT SOURCE	FEDERAL:	0%
OF FUNDING:	STATE:	100%
(PERCENT)	LOCAL:	0%
	PRIVATE:	0%
	TOTAL:	100%

PARTICIPANT PROFILE:	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	74 students 83 preceptorships*	72 students 86 preceptorships**	74 students 94 preceptorships***
% In-State Residents	_____	_____	_____
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

* 9 PCC students did mandatory 2-month preceptorships.

** 14 PCC students did mandatory 2-month preceptorships.

*** 20 PCC students did mandatory 2-month preceptorships.

New Mexico

PROGRAM (Date Initiated): New Mexico Osteopathic Student Loan Program
(1977)

ADMINISTRATIVE LOCUS: Private/Public

ADMINISTRATOR:

Director/Contact Person: Becky Mannon, BEF Program Representative
Address: New Mexico Educational Assistance Foundation
P.O. Box 27020
Albuquerque, NM 87125-7020
Telephone: 505-345-3371 ext.317

TYPE OF INCENTIVE: FINANCIAL INCENTIVES: Service-contingent Loans and
Scholarships

NARRATIVE DESCRIPTION:

This state-funded loan program provides up to \$8,000 per year to defray educational expenses of New Mexico residents enrolled in any accredited osteopathic medical school who are financially needy and who commit themselves to practice in an area designated as medically underserved by the program's advisory committee. The New Mexico Educational Assistance Foundation has administrative responsibility for disbursing loans and monitoring service requirements and paybacks, while the Commission on Higher Education processes and approves applications for aid. Recipients can have their loan forgiven on the following basis: a minimum of two years must be served, for which one year's loan will be forgiven; thereafter, the loan is cancelled on a one-for-one basis for each year of service.

GOALS:

1. Increase access to medical care in underserved rural areas.
2. Attract physicians to underserved rural areas.
3. Reduce financial barriers to medical training for state residents.

PARTICIPATING INSTITUTIONS: Medical schools

ELIGIBILITY: State resident, financial need, commitment to practice in medically underserved areas in the state.

AREA SELECTION CRITERIA: Other: approval on a case-by-case basis.

New Mexico

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ Not specified.	\$8,000	\$8,000	\$40,000	5

SERVICE OBLIGATION
Up to 6 years total - first year's loan is for 2 years of service, subsequent years' loans are cancelled on a 1 year of service for 1 year of loan basis up to 6 years (where 5 years of loans obtained).

BUYOUT PROVISIONS
Unpaid balance at 9% interest payable within 24 months.

STANDARDS FOR

PROGRAM EVALUATION: Legislature review of numbers of recipients who perform service obligation versus those who buy out.

OUTCOME: As of December 1985, 26 recipients were still in medical school, 10 were in residencies, 5 were in repayment status, and 2 were fulfilling their service obligations.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$</u>	<u>\$</u>	<u>\$150,000</u>

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

<u>PARTICIPANT PROFILE:</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #			25
% In-State Residents			100
% Training/Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

New Mexico

PROGRAM (Date Initiated): New Mexico Medical Student Loan Program (1975)

ADMINISTRATIVE LOCUS: Private/Public

ADMINISTRATOR:

Director/Contact Person: Becky Mannon, BEF Program Representative
Address: New Mexico Educational Assistance Foundation
P.O. Box 27020
Albuquerque, NM 87125-7020
Telephone: 505-345-3371 Ext. 317

TYPE OF INCENTIVE: FINANCIAL INCENTIVES: Service-contingent Loans and Scholarships

NARRATIVE DESCRIPTION:

This state-funded loan program provides up to \$8,000 per year to defray educational expenses of New Mexico residents enrolled in any accredited medical school who are financially needy and who commit themselves to practice in an area designated as medically underserved by the program's advisory committee. The New Mexico Educational Assistance Foundation has administrative responsibility for disbursing loans and monitoring service requirements and paybacks, while the Commission on Higher Education processes and approves applications for aid. The loan is fully forgiven by three years' of service, with 40 percent cancelled for the first year and 30 percent for each of the subsequent two years.

GOALS:

1. Increase access to medical care in underserved rural areas.
2. Attract physicians to underserved rural areas.
3. Reduce financial barriers to medical training for state residents.

PARTICIPATING INSTITUTIONS: Medical schools.

ELIGIBILITY: State resident, financial need, commitment to practice in state and in a medically underserved area.

AREA SELECTION CRITERIA: Other: approval on a case-by-case basis.

New Mexico

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ Not specified.	\$8,000	\$8,000	\$40,000	5

SERVICE OBLIGATION
3 years of service; 40% of loan, or \$6,000, whichever is greater, is forgiven for 1st year of service and 30% for each of the remaining 2 years.

BUYOUT PROVISIONS
Principal + 18% interest per year accruing from date of disbursement, payable within 48 months.

STANDARDS FOR

PROGRAM EVALUATION: Number of recipients who complete service obligation, versus those who buy out.

OUTCOME: As of December 1985, 26 recipients were still in medical school, 22 were in residencies, 16 in repayment status, 9 were fulfilling their service obligations, and 5 loans had been paid off, either by service or in cash payback.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$	\$	\$200,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 100%
LOCAL: 0%
PRIVATE: 0%
TOTAL: 100%

PARTICIPANT PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #		28	24
% In-State Residents		100	100
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

New Mexico

PROGRAM (Date Initiated): New Mexico Health Resources, Inc. (1981)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: Harriette Barber, R.N., M.P.H.
Executive Director

Address: New Mexico Health Resources, Inc.
P.O. Box 27650

Albuquerque, NM 87125
Telephone: 505-242-0633

TYPE OF INCENTIVE: AID IN PRACTICE: Placement

NARRATIVE DESCRIPTION:

The mission of New Mexico Health Resources, Inc., (NMHR) is to attract and retain health care professionals for New Mexico's rural and medically underserved areas. NMHR operates a recruiting system which helps communities identify, interview, and screen practitioners to serve their citizens. It provides a central source of information on health manpower needs, responding to inquiries from physicians, nurses, and other health practitioners interested in relocating. Through a careful matching of practitioner and community, NMHR seeks to promote long-term retention of those recruited. The staff also provides technical and management assistance to communities and health professionals recruited. As the program has developed, the focus of efforts has expanded to include placement for nurses, nurse practitioners, physician assistants, and physical therapists. NMHR will also provide placement services for nonshortage communities and sites on a fee-for-service basis.

GOALS:

1. Increase the numbers and improve the distribution of qualified health professionals in underserved New Mexico (e.g., through New Mexico Nursing Student Loan Program, Home Grown Recruitment Program).
2. Provide technical assistance to health care facilities to recruit and retain professionals; develop model programs; educate professionals.
3. Act as a facilitator among diverse groups of health professionals to implement change.
4. Perform objective, nonpartisan special studies to obtain necessary data to implement change.
5. Bolster the infrastructure of the health care delivery system by strengthening networks and capabilities.

New Mexico

PARTICIPATING INSTITUTIONS: Hospitals, primary care clinics, group and individual practice, medical school, GME programs, state health department.

CLINICAL SPECIALTIES: Primary care.

AREA SELECTION CRITERIA: HMSA

STANDARDS FOR
PROGRAM EVALUATION:

OUTCOME:

ANNUAL FUNDING LEVELS:	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	\$100,000	\$110,000	\$125,000

CURRENT SOURCE OF FUNDING: (PERCENT)	FEDERAL: 0%
	STATE: 50%
	LOCAL: 0%
	PRIVATE: <u>50%</u>
	TOTAL: 100%

NOT RELEVANT TO THIS PROGRAM

PARTICIPANT PROFILE:	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	_____	_____	_____
% In-State Residents	_____	_____	_____
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

New Mexico

PROGRAM (Date Initiated): Physician Recruitment Program (1978)

ADMINISTRATIVE LOCUS: Nonprofit corporation operating a multihospital system

ADMINISTRATOR:

Director/Contact Person: Bill Norris, Physician Recruitment
Address: Medical Practice Coordinator
Southwest Community Health Services
P.O. Box 2666
Albuquerque NM 87126-6666

Telephone: 505-823-8300

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES: Loans**

NARRATIVE DESCRIPTION:

Southwest Community Health Services (SCHS) is a nonprofit, multihospital system which includes Presbyterian Hospital in Albuquerque and 13 other hospitals in New Mexico. Its recruitment program operates a revolving loan fund to provide start-up funds for physicians willing to locate in underserved areas. In return for a one-year, interest-free loan, the physician assigns his/her accounts receivable to the corporation, which manages these accounts until the principal is repaid. Since late 1985, loan recipients have been liable for payment of 12% interest on unpaid loan balances after one year. On a case-by-case basis, a physician may renegotiate for continuation of an interest-free loan beyond one year. SCHS also provides technical assistance, continuing medical education, and a referral network for physicians to decrease the isolation of rural practice. Recruitment has also expanded to include nurse practitioners and physician's assistants.

GOALS:

1. Increase access to medical care in underserved rural areas.
2. Attract physicians to underserved rural areas.

PARTICIPATING INSTITUTIONS: Hospitals, ambulatory care facilities, group practices, private practices, rural health clinics.

ELIGIBILITY: MD or DO licensed to practice in New Mexico; NP or PA.

AREA SELECTION CRITERIA:

New Mexico

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$45,000	\$80,000	\$	\$125,000	1 (interest free)
<u>SERVICE OBLIGATION</u>		<u>BUYOUT PROVISIONS</u>		

STANDARDS FOR

PROGRAM EVALUATION: Number of physicians remaining in placement areas.

OUTCOME: Over 100 physicians recruited and placed since program's inception.
Net attrition to date is only 3 physicians.

ANNUAL FUNDING
LEVELS:*

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$3,500,000	\$3,500,000	\$3,500,000

* Amount of loans outstanding

CURRENT SOURCE	FEDERAL:	0%
OF FUNDING:	STATE:	0%
(PERCENT)	LOCAL:	0%
	PRIVATE:	100%
	TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	15*	15*	15*
% In-State Residents			0
% Training/ Practicing in Rural Setting			100%
% Rural Origin			
% Male/Female			20
% Minority			20

* Estimate

NEW YORK
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
X	X	X	X	X						

X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

New York

PROGRAM (Date Initiated): Family Practice Residency Funding (1974)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: John Jack, Ph.D., Director
Address: Health Planning Research
New York Department of Health
Swan Building, Core 1, 2nd Floor
Albany, NY 12237
Telephone: 518-474-7760

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Primary Care Residencies

NARRATIVE DESCRIPTION:

The Family Practice Residency Funding Program provides seat purchase grants to accredited family practice residency programs in New York State to defray a part of their operating costs. Funds may be used for any valid program purpose except capital construction. Currently, the program is funding 392 residents in 21 training programs throughout the state.

The numbers of programs and physicians in training have stabilized in recent years, after an initial period of expansion. Funding levels for the program have doubled in the current fiscal year, and risen again for fiscal year 1986-87.

- GOALS:
1. Increase the number of physicians in family practice.
 2. Achieve a balance of physician supply with demand/need for care.
 3. Retain state medical graduates in the state.

PARTICIPATING INSTITUTIONS: Graduate medical training programs.

CLINICAL SPECIALTIES: Family practice.

AREA SELECTION CRITERIA:

STANDARDS FOR

PROGRAM EVALUATION: 1) Practice locations of graduates; 2) fiscal soundness of program; 3) accreditation status; 4) medical education credentials of residents.

OUTCOME: Report on practice locations, etc., of graduates are tabulated on the basis of whether they are within New York state. Program monitors other aspects of funded training programs by mail, phone, and site visits.

New York

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$1,250,000	\$1,250,000	\$1,250,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	385-390	385-390	392
% In-State Residents	_____	_____	_____
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

New York

PROGRAM (Date Initiated): Greater Mohawk Valley Regional Medical Education Alliance (1979)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: Warren Marcus, M.P.H., M.S., Executive Director
Address: Greater Mohawk Valley Regional Medical Alliance
New York Department of Health
258 Genessee Street, Suite #309
Utica, NY 13502
Telephone: 315-792-3049

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Preceptorships

NARRATIVE DESCRIPTION:

The Alliance coordinates undergraduate preceptorships for medical students from New York State medical schools as well as from outside the state through a network of participating voluntary preceptor physicians in a wide variety of clinical settings located throughout central New York. Preclinical preceptorships are available for 18 first- and second-year students and between 70 and 80 third- and fourth-year students. The program places a major emphasis on primary care, but clinical experiences are available in 22 specialties. The program has also encouraged preceptorship experiences in specialized areas of health care; for example, developmental disabilities, substance abuse, women's health care, and geriatrics. The Alliance also offers continuing medical education to physicians in the region, puts out a monthly publication, and has developed a computerized medical literature data base.

GOALS:

1. Provide medical students with quality clinical experiences in rural and small cities in New York state.
2. Increase access to medical care in underserved rural areas.
3. Attract physicians to underserved rural areas.

PARTICIPATING INSTITUTIONS: Medical school, graduate medical education training programs, college/university, hospitals, ambulatory care facilities, group practice, private practice. HMOs, IPAs, county health departments.

CLINICAL SPECIALTIES: All with primary care emphasis.

AREA SELECTION CRITERIA:

New York

STANDARDS FOR
PROGRAM EVALUATION: None established yet; in planning stage and should be
in place in 1986.

OUTCOME:

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$163,000	\$163,000	\$163,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0.0%
STATE:	95.0%
LOCAL:	2.5%
PRIVATE:	2.5%
TOTAL:	100.0%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	88-98	88-98	88-98
% In-State Residents	90	90	90
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

New York

PROGRAM (Date Initiated): Clinical Campus of SUNY Health Science Center at Syracuse, College of Medicine (1977)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Edward A. Wolfson, M.D., MPH
Address: Dean, Clinical Campus
SUNY Health Science Center at Syracuse, SUNY
Binghamton, NY 13901
Telephone: 607-777-4805

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Other Curriculum Changes

NARRATIVE DESCRIPTION:

The SUNY Health Science Center's Clinical Campus at Binghamton offers a clinical training program for selected third- and fourth-year undergraduate medical students from the Syracuse medical campus. Program emphasis is on primary care in settings other than tertiary medical centers. Through curriculum changes, decentralized training, preceptorships and other educational mechanisms, the program seeks to influence medical students to choose primary care practice in rural underserved areas.

GOALS:

1. Maintain number of physicians in primary care.
2. Increase access to medical care in underserved rural areas.
3. Achieve a balance of physician supply with projected need or demand for medical care.

PARTICIPATING INSTITUTIONS: Medical school GHE programs, hospitals, ambulatory care facilities, group practice, private practice, nursing homes.

CLINICAL SPECIALTIES: Primary care.

AREA SELECTION CRITERIA:

STANDARDS FOR

PROGRAM EVALUATION: Career choices of Clinical Branch students vs. those of Syracuse-based medical students.

OUTCOME: Studies currently underway, results not yet available.

New York

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$1,686,900	\$1,901,400	\$1,982,700

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	80	80	80
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	100	100	100
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

New York

PROGRAM (Date Initiated): Sophie Davis School of Biomedical Education
Program of CUNY (1973)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Mort Slater, Ph.D., Director of Admissions
Address: City University Medical School
138th St. Covenant Avenue, Science Bldg.
New York, NY 10031
Telephone: 212-690-8256

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Other Curriculum Changes

NARRATIVE DESCRIPTION:

This program combines four years of undergraduate education leading to a B.S. degree with the first two years of medical school. The program is in the process of becoming a full four-year medical curriculum, pending accreditation. Currently, students transfer for their clinical years to one of eight cooperating medical schools after completing five years in the Sophie Davis program. Through selective recruitment of applicants from medically underserved areas and populations and by utilizing extensive community medicine training including exposure to medically underserved areas, the program prepares primary care physicians for service in such areas. Entering students make a commitment in writing to practice in urban areas upon completion of primary care residency training programs.

GOALS:

1. Increase access to medical care in underserved urban areas.
2. Promote medical career opportunities for economically disadvantaged or other minority groups.
3. Reduce financial barriers to medical training for state residents.

PARTICIPATING INSTITUTIONS: Medical Schools, University.

CLINICAL SPECIALTIES: Primary care.

AREA SELECTION CRITERIA: State criteria (see Chapter Three)

STANDARDS FOR
PROGRAM EVALUATION: Internal Review. The school maintains records of the students' choices of residency programs.

New York

OUTCOME: Number of students in underserved areas; current statistics 1983, 1984, 1985 unavailable.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$2,400,000	\$3,500,000	\$6,100,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	4%
STATE:	91%
LOCAL:	0%
PRIVATE:	<u>5%</u>
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983*</u>	<u>1984*</u>	<u>1985</u>
Total #	331	331	331
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	0	0	0
% Rural Origin	0	0	0
% Male/Female	57/43	57/43	57/43
% Minority	22	22	22

* Estimate

New York

PROGRAM (Date Initiated): New York State Contract Program (1976)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Thomas Shea, Associate Coordinator for
Institutional Aid

Address: Office of Policy Analysis, Room 5-B44
Cultural Education Center
NY State Education Department

Albany, NY 12230
Telephone: 518-474-5091

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Seat Purchase

NARRATIVE DESCRIPTION:

New York State contracts with five medical schools and one dental school outside the state to provide places for qualified state residents. Contracting schools agree to reserve first-year places for New York residents as follows: University of Vermont College of Medicine -- at least 10 and not more than 20; Sackler School of Medicine (Tel Aviv, Israel) -- 20 to 40; Morehouse School of Medicine (Atlanta) -- 4 to 8; Meharry School of Medicine (Nashville) -- 8 to 10; University of Puerto Rico -- 5 to 8; and Meharry School of Dentistry -- 5 to 8. Places in the last four programs are reserved for applicants from financially disadvantaged and minority backgrounds. Contract students are eligible for all financial assistance as if they were attending medical or dental school in New York. The Commissioner of Education pays the institution on a seat purchase basis. The students may be charged no more than tuition and fees required of nonresident students. Participants agree to practice medicine in a designated medically underserved area for at least three years following completion of training.

GOALS:

1. Increase access to medical care in underserved urban and rural areas.
2. Promote medical and dental career opportunities for qualified state residents.
3. Promote medical and dental career opportunities members of minority groups.

PARTICIPATING INSTITUTIONS: Medical schools, dental schools, colleges

ELIGIBILITY: State resident, underrepresented minority for
Morehouse, Meharry, commitment to practice in a
shortage area.

AREA SELECTION CRITERIA: State criteria (See Chapter Three)

New York

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$6,000 (Currently, Sackler, U. of Vermont)	\$15,000 (currently for Morehouse)	\$ depends on school	\$60,000	4

SERVICE OBLIGATION
36 months or 9 months
service for each year's
award (up to four years)
following completion of
training.

BUYOUT PROVISIONS
A = 2B (36-5)
36

Twice the sum of all payment
plus interest at rates prevail-
ing at time of such payment
were made less 1/36 for each
month served in designated
area. Repayment due within 1
year of failure to fulfill
service obligation.

STANDARDS FOR

PROGRAM EVALUATION:

Numbers of graduates fulfilling service obligations.

OUTCOME: As of 9/85, 112 graduates of University of Vermont - 94 still in
residency; 19 have submitted plans to serve; 3 are in service, 6 are
in payback. 180 graduates of Sackler; 154 in residency; 19 plans
submitted, 6 in service, 1 in pay back. First graduates of
Morehouse and Meharry were in June 1985.

ANNUAL FUNDING

LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$2,048,000	\$2,131,000	\$2,073,637

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT PROFILE:

	<u>1983</u>		<u>1984</u>		<u>1985</u>	
	MD	DDS	MD	DDS	MD	DDS
Total #	247	2	257	5	276	5
% In-State Residents	100	100	100	100	100	100
% Training/ Practicing in Rural Setting						
% Rural Origin						
% Male/Female	74/26	50/50	73/27	40/60	71/29	40/60
% Minority	9	100	13	100	17	100

New York

PROGRAM (Date Initiated): Regent Health Care Scholarships (1985)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Henry T. Weaver, Assistant Supervisor of
Educational Training
Address: Bureau of Higher and Professional Education
NY State Department of Education
Cultural Education Center
Albany, NY 12230
Telephone: 518-474-6394

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES:** Service-contingent Loans and
Scholarships

NARRATIVE DESCRIPTION:

Legislation enacted in 1985 established 50 scholarships per year for economically disadvantaged and minority students enrolled in approved medical or dental schools in New York or in one of the schools participating in the New York Contract program. Economic disadvantage is based on total family annual income and household size. For purposes of the scholarships, minorities historically underrepresented in the health professions include Black, Hispanic, native American Indian or Alaska natives who are residents of New York state. The scholarships require a service commitment in an area designated as medically (or dentally) underserved by the Regents of the State of New York. Recipients must practice 12 months in an underserved area for each annual award, but in no case less than 24 months. The first awards under the program were made in 1986.

GOALS:

1. Promote medical and dental careers for economically disadvantaged and underrepresented minority groups.
2. Attract physicians and dentists to underserved urban and rural areas.

PARTICIPATING INSTITUTIONS: Higher Education Services Corporation, Medical Schools/Dental Schools

ELIGIBILITY: U.S. citizen or resident alien; state resident; financial need; ethnic or racial minority "historically underrepresented in the profession," commitment to practice in underserved area in the state.

AREA SELECTION CRITERIA: State criteria (See Chapter Three)

New York

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$1,000	\$10,000*	\$10,000	\$40,000	4

* Not to exceed actual cost of attendance

SERVICE OBLIGATION
12 months of service for
each \$10,000 award with
minimum requirements of
24 months.

BUYOUT PROVISIONS
200% remaining principal
+ maximum prevailing
interest rate, payable
within 5 years.

STANDARDS FOR

PROGRAM EVALUATION:

Success in attracting minorities to careers in medicine and dentistry and to practice in underserved areas.

OUTCOME: New program

ANNUAL FUNDING
LEVELS:*

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
_____	_____	_____

* Established in 1985

CURRENT, SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 100%
LOCAL: 0%
PRIVATE: 0%
TOTAL: 100%

PARTICIPANT PROFILE*

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	_____	_____	_____
% In-State Residents	_____	_____	_____
% Training/Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

* Established in 1985; first year of operation 1986.

New York

PROGRAM (Date Initiated): Regents Physician Loan Forgiveness Program
(1985)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Henry T. Weaver
Assistant Supervisor of Educ. Testing
Address: Bur. Higher & Profession Education
New York State Department of Education
Albany, NY 12230
Telephone: 518-474-6394

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES: Service-contingent Loans and Scholarships**

NARRATIVE DESCRIPTION:

The Loan Forgiveness Program, enacted in 1985, provides 50 awards of \$10,000 annually for up to two years to physicians who have recently completed their training and who agree to practice medicine in a designated medically underserved area. The award to an individual physician will be equal to undergraduate and medical school loan and loan interest expenses up to a maximum of \$20,000. Recipients who have incurred loans in excess of that amount may apply for one additional two-year award. The minimum period of service is 24 months, and failure to complete the service requirement obligates the recipient to pay twice the amount of the unpaid balance plus interest at the maximum prevailing rates. Preference for loans is given to applicants who have completed residencies in family practice or primary care specialties.

GOALS:

1. Attract physicians to underserved urban and rural areas.
2. Increase the number of physicians in primary care.

PARTICIPATING INSTITUTIONS: Higher Education Services Corporation.

ELIGIBILITY: U.S. citizen or resident alien, state resident, commitment to practice in medically underserved area; completed residency training within 5 years prior to award; licensed in New York prior to beginning services; not a recipient physician of Regents Shortage Scholarship.

AREA SELECTION CRITERIA: State criteria (see Chapter Three).

New York

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ not specified	\$10,000	\$10,000	\$20,000*	2**

* Not to exceed educational indebtedness.

** May be renewed for one additional 2-year award for recipient whose debt exceeds \$20,000.

SERVICE OBLIGATION
Minimum of 2 years served
to have loan forgiven.

BUYOUT PROVISIONS
200% of unpaid balance +
maximum prevailing interest.

STANDARDS FOR

PROGRAM EVALUATION: Not yet established. Probably will be done by Higher Education Services Corporation.

OUTCOME:

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$ *</u>	<u>\$ *</u>	<u>\$ *</u>

* Beginning FY 1986 - \$500,000 (50 awards of \$10,000).

CURRENT SOURCE	FEDERAL:	0%
OF FUNDING:	STATE:	100%
(PERCENT)	LOCAL:	0%
	PRIVATE:	0%
	TOTAL:	100%

<u>PARTICIPANT PROFILE*</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	_____	_____	_____
% In-State Residents	_____	_____	_____
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

* Established in 1985; first year of operation 1986.

NORTH CAROLINA
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
				X			X			X

- X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

North Carolina

PROGRAM (Date Initiated): North Carolina Student Loan Program for Health, Science and Mathematics (1945)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Dr. Debra A. Reddin
Address: Office of State Budget and Management
116 West Jones Street, Suite 279
Raleigh, NC 27611
Telephone: 919-733-2164

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES: Service-contingent Loans and Scholarships**

NARRATIVE DESCRIPTION:

This state-funded program provides loans for undergraduate medical and dental students, associate to masters level nursing students, optometry students, and allied health students who are state residents and agree to serve in a Health Manpower Shortage Area, a community of fewer than 10,000 people, or a state or county facility, such as a health department or prison upon completion of training.

In 1983, the program eliminated its service component and became a conventional loan program. As a loan program, it was not competitive with other loan programs and did not attract new students. In 1985, the program reinstated the service provision.

- GOALS:
1. Increase access to medical care in underserved rural areas.
 2. Attract health professionals to underserved rural areas.

PARTICIPATING INSTITUTIONS: Any accredited U.S. health professions school

ELIGIBILITY: North Carolina resident; financial need; good academic standing; have cosigner for loan; in eligible professional training

AREA SELECTION CRITERIA: HMSA modification: HMSA; rural community of fewer than 10,000 people; state or local institutions.

North Carolina

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$	\$ 2,500 undergrad. \$ 3,000 graduates \$ 6,000 medical or dental	\$	\$10,000 \$ 6,000 \$24,000	3 or 4 (pharmacy) 2 4
<u>SERVICE OBLIGATION</u>		<u>BUYOUT PROVISIONS</u>		
One year for each year of loan.		Principal + 15% interest.		

STANDARDS FOR

PROGRAM EVALUATION: Completion of education; placement and retention

OUTCOME: A 1984 evaluation of obligated physicians and dentists showed: 60-80% continued to practice in state after obligation; over half remained at the site where placed.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$879,000	\$879,000	\$879,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	350	350	360
% In-State Residents	100	100	100
% Training/Practicing in Rural Setting	100	100	100
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

North Carolina

PROGRAM (Date Initiated): Area Health Education Centers (AHEC) (1972)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Eugene S. Mayer, MD
Address: Wing C, School of Medicine
221 H
Chapel Hill, NC 27514
Telephone: 919-966-2461

TYPE OF INCENTIVE: AID IN PRACTICE: AHECs

NARRATIVE DESCRIPTION:

This network of nine AHEC sites in partnership with four university health science centers provides community-based educational experiences for health professional students, develops over 300 primary care residencies, and provides community-based continuing education accessible to health practitioners and support personnel throughout the state.

GOALS:

1. Attract and retain health professionals in underserved areas.
2. Increase the number of physicians in underserved areas.

PARTICIPATING INSTITUTIONS: University of North Carolina at Chapel Hill; Duke University Medical Center; Bowman Gray School of Medicine; East Carolina University

CLINICAL SPECIALTIES: Medicine, Nursing, Public Health, Dentistry, Pharmacy, Allied Health

AREA SELECTION CRITERIA:

STANDARDS FOR

PROGRAM EVALUATION: Addressing needs of underserved areas for recruitment and retention of health professionals.

OUTCOME: For family practice residents training in the AHECs, 70 percent stay in state with 51 percent of those settling in towns of under 5,000 people. Of medical school graduates graduating between 1975-1977, between 30 and 53 percent chose to remain in state. Finally, 89 of 100 counties have improved their physician-to-population ratio.

North Carolina

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$20,000,000*	\$20,000,000*	\$23,200,000*

* State and federal

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0.4%
STATE:	65.6%
LOCAL:	34.0%
PRIVATE:	0.0%
TOTAL:	100.0%

NOT RELEVANT TO THIS PROGRAM

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #			
% In-State Residents			
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

North Carolina

PROGRAM (Date Initiated): Office of Rural Health Services (1973)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: James Bernstein
Address: 701 Barbour Drive
Raleigh, NC 27603
Telephone: 919-733-2040

TYPE OF INCENTIVE: AID IN PRACTICE: Placement

NARRATIVE DESCRIPTION:

This state program develops community-sponsored rural health centers (including providing facility and equipment capital on a matching basis), recruits physicians, and coordinates placement of National Health Service Corpsmen within North Carolina.

GOALS:

1. Increase access to medical care in underserved rural areas.
2. Attract physicians to underserved rural areas.

PARTICIPATING INSTITUTIONS: Office of Rural Health, rural health clinics

CLINICAL SPECIALTIES: Primary care

AREA SELECTION CRITERIA: HMSA

STANDARDS FOR

PROGRAM EVALUATION: Placement and retention of physicians and development of self-supporting, community-sponsored rural health centers.

OUTCOME: Development of 40 community-sponsored rural health centers, 75% are self-supporting. Placement of 594 physicians in 10 years. 60% of all private placements in practice for at least 5 years have remained at site.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$1,638,352*	\$1,857,525*	\$1,861,024*

* Funding covers technical, operating, and capital assistance provided by the office.

North Carolina

CURRENT SOURCE	FEDERAL:	16%
OF FUNDING:	STATE:	84%
(PERCENT)	LOCAL:	0%
	PRIVATE:	<u>0%</u>
	TOTAL:	100%

PARTICIPANT PROFILE:	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	78	57	72
% In-State Residents	33	37	24
% Training/ Practicing in Rural Setting	<u>88</u>	<u>95</u>	<u>93</u>
% Rural Origin	<u></u>	<u></u>	<u></u>
% Male/Female	78/22	84/16	78/22
% Minority	19	16	13

NORTH DAKOTA
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
				-			X			

X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

North Dakota

PROGRAM (Date Initiated): Office of Rural Health (1980)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Kevin Fickenschner, M.D., Director
Address: Office of Rural Health -- School of Medicine
University of North Dakota
Grand Forks, ND 58202
Telephone: 701-777-3294

TYPE OF INCENTIVE: AID IN PRACTICE: Placement

NARRATIVE DESCRIPTION:

The activities of the Office of Rural Health are focused on increasing access to primary care services in rural communities of North Dakota. The office offers technical assistance to underserved areas in determining health provider needs and recruiting physicians to the area, provides assistance to physicians in establishing a rural practice through practice management counseling, and coordinates new programs with the existing rural health care system.

- GOALS:
1. Attract physicians to underserved rural areas.
 2. Increase access to medical care in underserved rural areas.
 3. Retain state medical graduates within the state.

PARTICIPATING INSTITUTIONS: Medical schools, graduate medical training programs, colleges, hospitals, ambulatory care facilities, group practices, private practices.

CLINICAL SPECIALTIES: General practice, family practice, internal medicine, pediatrics

AREA SELECTION CRITERIA: HMSA

STANDARDS FOR
PROGRAM EVALUATION: Program is planning to develop a research and analysis component to develop outcome measures.

OUTCOME:

North Dakota

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$397,089	\$495,414	\$647,915

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	10%
STATE:	20%
LOCAL:	0%
PRIVATE:	<u>70%</u>
TOTAL:	100%

PARTICIPANT
PROFILE:

Program conducts mailings to residents and counsels physicians on practice opportunities. They individually assist from 5,000-7,500 physicians per year.

NOT RELEVANT TO THIS PROGRAM

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	_____	_____	_____
% In-State Residents	_____	_____	_____
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

OHIO
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
		X	-	X						

X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

Ohio

PROGRAM (Date Initiated): Ohio State University Community Medicine
Rotation (1971)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Franklin R. Banks, M.D., Assoc. Prof.

Address: Department of Preventive Medicine

The Ohio State University

410 W. 10th Avenue

Columbus, OH 43210

Telephone: 614-421-3908

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Preceptorships

NARRATIVE DESCRIPTION:

Ohio State University Medical School originally established a community medicine rotation as a required part of its curriculum in 1977. In 1979 the University made the rotation optional and approximately one-third of the students currently participate. Students spend a minimum of 4 weeks in a rotation with a practicing physician at a site of their choice. Students receive full academic credit for the rotation. The University does not provide stipends but provides counseling to match students with grants. The program also coordinates activities with the local AHEC at The Ohio State University.

- GOALS:
1. Provide clinical training in a health care delivery system away from a university setting.
 2. Attract physicians to underserved areas.
 3. Provide students with opportunities to study health care delivery systems.

PARTICIPATING INSTITUTIONS: Medical school, practicing physicians, AHEC site, community hospitals, and other community institutions.

CLINICAL SPECIALTIES: Primary care and preventive medicine.

AREA SELECTION CRITERIA:

STANDARDS FOR
PROGRAM EVALUATION: Systematic evaluations obtained from faculty, field preceptors, and students.

OUTCOME: Enhancement of student knowledge of preventive medicine, primary care, and health care delivery.

Ohio

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$ 0</u>	<u>\$ 0</u>	<u>\$ 0</u>

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	0%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	0%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	80	80	80
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	10	10	10
% Rural Origin	<u> </u>	<u> </u>	<u> </u>
% Male/Female	66/33	66/33	66/33
% Minority	<u> </u>	<u> </u>	<u> </u>

PROGRAM (Date Initiated): Preferred Placement Program (1972)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Howard S. Madigan, M.D., Associate Dean
Address: Medical College of Ohio
C.S. 10008
Toledo, OH 43699
Telephone: 419-381-4237

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES:** Service-contingent Loans and Scholarships

NARRATIVE DESCRIPTION:

Preferred Placement is a program which enables communities in need of physicians to support a medical student for part of his/her medical education in return for an agreement for practice in that community. The community establishes a nonprofit organization for the purpose of health professions recruiting. Many students request communities near their hometowns, and some students initiate arrangements with organizations in their hometowns.

Students receive interest-free loans during their second, third, and fourth years (no first-year students are eligible for the program because it is felt that is too early to make commitments at that point) in return for an agreement to practice in that community for one year longer than the number of years of assistance. The communities interact with the students frequently, and it is felt that the success of the program depends on the bonds forged between the student and the community before the student's graduation.

Recently, the size of the program has declined, due to a decrease in the number of communities in need. The default rate over the life of the program has been very low, and usually has occurred due to circumstances in the community. Medical College of Ohio works with other medical schools in the state to accommodate their students in the program.

GOALS:

1. Reduce financial barriers to training for state residents.
2. Match communities in need with physicians.
3. Encourage physicians to practice in underserved areas.

PARTICIPATING INSTITUTIONS: Medical schools, communities.

ELIGIBILITY: Financial need, commitment to practice in a specific community.

AREA SELECTION CRITERIA:

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ _____	\$ _____	\$13,000	\$40,000	3
<u>SERVICE OBLIGATION</u>		<u>BUYOUT PROVISIONS</u>		
Practice in community for one year longer than the number of years of aid.		125% of principal + interest, payable within 3 years.		

STANDARDS FOR

PROGRAM EVALUATION: Number of participants fulfilling obligation.

OUTCOME: Very few have defaulted.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$ *	\$ *	\$ *

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	0%
LOCAL:	100%
PRIVATE:	0%
TOTAL:	100%

* Amounts vary by community. Medical College of Ohio's only costs are for administration, approximately \$30,000 per year.

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	65	65	65
% In-State Residents	_____	_____	_____
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	85	85	85
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

OKLAHOMA
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
X				X			X			X

X = Presence of program.
+ = Program added since 1981.
- = Program discontinued since 1981.

Oklahoma

PROGRAM (Date Initiated): Oklahoma Intern-Resident Cost Sharing Program
(1975)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Ralph O. Morgan, Jr., Executive Director
Address: Physician Manpower Training Commission
Northeast 10th and Stonewall
P.O. Box 53551, Room 710
Oklahoma City, OK 73152
Telephone: 405-271-5848

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Primary Care Residencies

NARRATIVE DESCRIPTION:

The Physician Manpower Training Commission is charged by the state to administer several programs aimed at achieving adequate physician distribution in Oklahoma. Among these is the Intern-Resident Cost Sharing Program, a salary cost sharing program for primary medical care and family practice internship and residency training programs throughout the state with emphasis on rural areas.

In the time span in which the Physician Manpower Training Commission has been responsible for the cost sharing program, a total of 303 primary medical care residency and internship positions have been developed in the state. The latest figures show the state is now able to provide residency positions for all of its graduating medical students and most osteopathic graduates.

GOALS:

1. Provide residencies for state medical graduates.
2. Encourage physicians to practice in primary care and family practice.
3. Encourage physicians to practice in rural areas.

PARTICIPATING INSTITUTIONS: Hospitals, medical schools.

CLINICAL SPECIALTIES: Primary care

AREA SELECTION CRITERIA:

**STANDARDS FOR
PROGRAM EVALUATION:** Number of primary care residencies available.

Oklahoma

OUTCOME: The state is now able to provide residency positions for all of its graduating medical students and most osteopathic graduates. Outstanding progress has been made in expanding primary care internships and residency positions since 1975.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$5,372,858	\$5,241,686	\$4,936,378

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	50%
LOCAL:	50%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	_____	_____	_____
% In-State Residents	_____	_____	_____
% Training/Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

Oklahoma

PROGRAM (Date Initiated): Nursing Student Assistance Program (1982)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Ralph O. Morgan, Jr., Executive Director
Address: Physician Manpower Training Commission
Northeast 10th and Stonewall
P.O. Box 53551, Room 710
Oklahoma City, OK 73152
Telephone: 405-271-5848

TYPE OF INCENTIVE: FINANCIAL INCENTIVES: Service-contingent Loans and Scholarships

NARRATIVE DESCRIPTION:

The Nursing Student Assistance Program was established by the Oklahoma Legislature in 1982 and is administered by the Physician Manpower Training Commission. The purpose of this program is to provide assistance to Oklahoma nursing students pursuing LPN, ADN, BSN, or MSN degrees and who are interested in practicing nursing in Oklahoma communities, with emphasis placed on rural or smaller communities. Students may receive "matching" scholarships, where an institution sponsors a student and provides 50 percent of the scholarship; the state matches the amount. In return the student agrees to practice at that institution for one year for each year of aid. "Nonmatching" scholarships are scholarships provided by the state; in return, the student agrees to serve in the state for one year for each year of aid. Students may not fulfill their obligation by serving in federal hospitals or physician offices.

GOALS:

1. Match nurses with communities in need.
2. Retain state graduates within state.

PARTICIPATING INSTITUTIONS: Nursing schools, communities.

ELIGIBILITY: U.S. citizen, state resident, admitted to accredited nursing school.

AREA SELECTION CRITERIA: Other: Matching scholarship recipients must practice in sponsoring institutions; nonmatching scholarship recipients may practice anywhere in the state except federal hospitals or private physician offices.

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
Matching \$ 500	\$2,500	\$2,500	\$ None	2
Nonmatching \$ None	\$1,000	\$1,000	\$ None	2

SERVICE OBLIGATION:

One year for each year of
aid.

BUYOUT PROVISIONS:

Principal + 12% interest
+ penalty at discretion
of state.

STANDARDS FOR

PROGRAM EVALUATION: Number of students fulfilling practice obligation.

OUTCOME: Of 74 recipients of matching scholarships, 60% bought out their
obligation, 40% fulfilled. Of 53 recipients of non-matching
scholarships, 55% bought out their obligations, 45% fulfilled.

ANNUAL FUNDING
LEVELS:

FY 1983

\$117,229

FY 1984

\$132,128

FY 1985

\$114,467

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL 0%
STATE 100%
LOCAL 0%
PRIVATE 0%
TOTAL 100%

PARTICIPANT
PROFILE:

1983

1984

1985

TOTAL #

125

132

123

IN-SCHOOL
RESIDENTS

100

100

100

TRAINING/
PRACTICING IN
Rural Setting

Rural Origin

Male/Female

Minority

Oklahoma

PROGRAM (Date Initiated): Oklahoma Community Physician Education
Scholarship Loan Program (1973)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Ralph O. Morgan, Jr., Executive Director
Address: Physician Manpower Training Commission
Northwest 100th and Stonewall II
P.O. Box 53551, Room 7100
Oklahoma City, OK 73152
Telephones: 405-271-5848

TYPE OF INCENTIVE: FINANCIAL INCENTIVES: Service-contingent loans and
Scholarships

NARRATIVE DESCRIPTION:

This program was designed to match Oklahoma communities on a 50-50 basis (with the state portion not to exceed \$5,000 per student) to provide financial aid for students attending medical school in return for an agreement to practice in that community upon completion of training.

The Physician Manpower Training Commission is currently phasing out the program due to an improvement in physician distribution in the state and a resulting decline in need for the program.

GOALS:

1. Match physicians with communities in need.
2. Retain state medical graduates within the state.

PARTICIPATING INSTITUTIONS: Medical schools, communities.

ELIGIBILITY: State residents, financial needs, commitment to practice in a shortage area.

AREA SELECTION CRITERIA:

CONDITIONS:

MINIMUM ANNUAL AWARD	MAXIMUM ANNUAL AWARD	AVERAGE AWARD	OVERALL MAXIMUM AWARD	MAXIMUM YEARS OF AID
\$	\$10,000	\$	\$10,000	4

SERVICE OBLIGATION

BUYOUT PROVISIONS

One year per year of support, 200% principal + 10% interest.

STANDARDS FOR

PROGRAM EVALUATION: Number of students fulfilling practice obligation.

OUTCOME: Of 92 students:

28 students are still in training (30%);

39 are carrying out their obligation (42%);

25 have elected to pay back in lieu of service (28%).

ANNUAL FUNDING

LEIRES:

FY 1983

FY 1984

FY 1985

\$475,000

\$440,000

\$427,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 50%
LOCAL: 50%
PRIVATE: 0%
TOTAL: 100%

PARTICIPANT
PROFILE:

1983

1984

1985

Total #

21

18

8

% In-State
Residents

100

100

100

% Training/
Practicing in
Rural Setting

% Rural Origin

% Male/Female

% Minority

Oklahoma

PROGRAM (Date Initiated): Oklahoma Rural Medical Education Scholarship Loan Program (1975)

ADMINISTRATIVE AGENCY: State

ADMINISTRATOR:

Director/Contact Person: Ralph O. Morgan, Jr., Executive Director
Address: Physician Manpower Training Commission
Northeast 10th and Stonewall
P.O. Box 53551, Room 710
Oklahoma City, OK 73152
Telephone: 405-271-5848

TYPE OF INCENTIVE: FINANCIAL INCENTIVES: Service-contingent Loans and Scholarships

NARRATIVE DESCRIPTION:

The Physician Manpower Training Commission acts as administrator of the Rural Medical Education Scholarship Loan Program, which gives financial assistance to undergraduate medical students in return for service in a community with a population of 7,500 or fewer.

GOALS:

1. Assist state residents in attending medical school.
2. Encourage physicians to practice in rural areas.
3. Retain state medical graduates in state.

PARTICIPATING INSTITUTIONS: Medical schools.

ELIGIBILITY: State resident attending medical school.

AREA SELECTION CRITERIA: Community size: population of fewer than 7,500.

CONDITIONS:

~~MAXIMUM ANNUAL AWARD~~	MAXIMUM ANNUAL AWARD	AVERAGE AWARD	OVERALL MAXIMUM AWARD	MAXIMUM YEARS OF AID
3	\$7,000	\$7,000	\$28,000	4
SERVICE OBLIGATION		BUYOUT PROVISIONS		
One year per year of support.		Principal + 10% interest		

Oklahoma

STANDARDS FOR

PROGRAM EVALUATION:

Number of graduates remaining in rural areas after obligated practice.

OUTCOME: 72 percent of graduates remain in rural areas after obligated practice.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$355,000	\$286,825	\$251,319

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	<u>0%</u>
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	48	44	43
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

PROGRAM (Date Initiated): Physician Placement Program (1976)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Ralph O. Morgan, Jr., Executive Director
Address: Physician Management Training Commission
Northeast 10th and Stonewall, Room 710
P.O. Box 53551
Oklahoma City, OK 73152
Telephone: 405-271-5848

TYPE OF INCENTIVE: AID IN PRACTICE: Placement

NARRATIVE DESCRIPTION:

In 1976 the Oklahoma Legislature added the responsibility of a Physician Placement Program to the duties of the Physician Manpower Training Commission to help place, in rural areas, physicians other than those who were participating in the Commission's two scholarship programs. For several years, funding for this aspect of the Commission's program has been very restricted; however, the staff of the Commission worked cooperatively during this time with the Oklahoma State Medical Association and the Oklahoma Osteopathic Association to give limited assistance to communities recruiting physicians. Support is currently provided to the Offices of Physician Placement at the University of Oklahoma College of Medicine, the University of Oklahoma Tulsa Medical College, and the Oklahoma College of Osteopathic Medicine and Surgery. These offices provide assistance to the approximately 104 rural Oklahoma towns currently seeking physicians. Staff members contact all graduating physicians from Oklahoma medical schools to alert them of practice opportunities.

GOALS:

1. Match physicians with communities in need.
2. Encourage state medical graduates to practice in state.
3. Encourage physicians to practice in rural areas.

PARTICIPATING INSTITUTIONS: Medical schools, communities.

CLINICAL SPECIALTIES:

AREA SELECTION CRITERIA:

STANDARDS FOR
PROGRAM EVALUATION: Physician distribution.

OUTCOME: Dramatic improvement since 1976.

Ok lahoma

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$180,056	\$ 0	\$ 0

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 100%
LOCAL: 0%
PRIVATE: 0%
TOTAL: 100%

NOT RELEVANT TO THIS PROGRAM

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	_____	_____	_____
% In-State Residents	_____	_____	_____
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

PROGRAM (Date Initiated): Oklahoma AHEC (1984)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: David Hanny, Associate Director
Address: Oklahoma AHEC, Oklahoma College of
Osteopathic Medicine and Surgery
1111 West 17th St.
Tulsa, OK 74107
Telephone: 918-582-2724

TYPE OF INCENTIVE: AID IN PRACTICE: AHECs

NARRATIVE DESCRIPTION:

The AHEC program, administered in Tulsa through the Oklahoma College of Osteopathic Medicine and surgery, has two sites in the state which coordinate health professions education and continuing medical education activities for DOs, MDs, nurses, optometrists, and other health professionals. It also provides preceptorships for optometry students and operates a minority recruitment program. Through the minority recruitment program, Native American physicians sponsor undergraduate or osteopathic students and introduce them to the life of a physician. The AHEC plans to provide a public psychiatric residency program to train osteopathic psychiatrists for the public sector. The AHEC also conducts analyses of health manpower needs.

GOALS: 1. Promote the distribution of health professionals in the state.

PARTICIPATING INSTITUTIONS: AHEC sites, providers, health care institutions, health associations, health professions schools.

CLINICAL SPECIALTIES: Osteopathic, general and family practice, osteopathic psychiatry.

AREA SELECTION CRITERIA: HMSA

STANDARDS FOR
PROGRAM EVALUATION: None specified.

OUTCOME: Program in early stages; too early for outcomes.

ANNUAL FUNDING LEVELS:	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	\$ 0*	\$ 0*	\$200,000*

* First program year was 1985.

Oklahoma

CURRENT SOURCE	FEDERAL:	75%
OF FUNDING:	STATE:	25%
(PERCENT)	LOCAL:	0%
	PRIVATE:	0%
	TOTAL:	100%

NOT RELEVANT TO THIS PROGRAM

**PARTICIPANT
PROFILE:**

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	_____	_____	_____
% In-State Residents	_____	_____	_____
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

OREGON
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
X							X			

X = Presence of program.
+ = Program added since 1981.
- = Program discontinued since 1981.

Oregon

PROGRAM (Date Initiated): Family Practice Residency (1970)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: John Saultz, M.D., Director
Address: Oregon Health Sciences University
Portland, OR 97201
Telephone: 503-225-7590

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Preceptorships

NARRATIVE DESCRIPTION:

The Family Practice Residency program provides preceptorships for undergraduate medical students to encourage them to choose rural family practice specialties and also provides residency experiences for graduate medical students in small communities in the state. The program also runs a family practice residency program with eight positions per year.

GOALS:

1. Increase the number of physicians in primary care and/or family practice.
2. Attract physicians to underserved rural areas.
3. Increase access to medical care in underserved rural areas.

PARTICIPATING INSTITUTIONS: Medical schools, osteopathic schools.

CLINICAL SPECIALTIES: Family practice.

AREA SELECTION CRITERIA: Other: Designation by State Board of Medical Examiners on a case-by-case basis.

STANDARDS FOR
PROGRAM EVALUATION: Evaluation of specific criteria by preceptors, preceptees, and staff; measurement of the impact of the preceptorship on student attitudes toward family medicine.

OUTCOME: 25% of students in preceptorships. 25% of medical school graduates choose family practice residencies.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$600,000	\$600,000	\$1,000,000

Oregon

CURRENT SOURCE OF FUNDING: (PERCENT)	FEDERAL: 25%
	STATE: 65%
	LOCAL: 0%
	PRIVATE: <u>15%</u>
	TOTAL: 100%

PARTICIPANT PROFILE:	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	15	23	14
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	33	56	50
% Rural Origin	<u> </u>	<u> </u>	<u> </u>
% Male/Female	47/53	56/44	50/50
% Minority	0	0	0

Oregon

PROGRAM (Date Initiated): Office of Rural Health (1979)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Marsha Kilgore, Director
Address: Office of Rural Health
State Health Planning & Development Agency
3886 Beverly N.E., Suite 19
Salem, OR 97305
Telephone: 503-378-4068

TYPE OF INCENTIVE: AID IN PRACTICE: Placement

NARRATIVE DESCRIPTION:

The Office of Rural Health acts as a clearinghouse for information regarding rural health care delivery systems and is responsible for the coordination of statewide efforts to provide health care in rural areas. Activities include a strategic plan for primary care in rural areas; maintenance and dissemination of a database containing socioeconomic, demographic, provider and other information on 103 non-metropolitan service areas; an informal physician and mid-level professionals community match-up service; a small grants-in-aid program for primary care projects throughout the state; and technical assistance in the development, implementation, and continuation of rural health care programs.

GOALS:

1. Increase access to care in rural areas.
2. Coordinate statewide rural health efforts.
3. Attract providers to underserved rural areas.

PARTICIPATING INSTITUTIONS: Providers and communities in rural areas.

CLINICAL SPECIALTIES: Primary care

AREA SELECTION CRITERIA: State criteria (See Chapter Three)

STANDARDS FOR
PROGRAM EVALUATION: Number of activities and communities involved; quality of care in rural areas.

OUTCOME: Improvement since the Office was established in 1979.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$218,494	\$200,828	\$222,340

CURRENT SOURCE	FEDERAL:	44%
OF FUNDING:	STATE:	56%
(PERCENT)	LOCAL:	0%
	PRIVATE:	0%
	TOTAL:	100%

NOT RELEVANT TO THIS PROGRAM

PARTICIPANT
PROFILE:

	1983	1984	1985
Total #			
% In-State Residents			
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

PENNSYLVANIA
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
		X	X		X		-			

X = Presence of program.
+ = Program added since 1981.
- = Program discontinued since 1981.

Pennsylvania

PROGRAM (Date Initiated): Preceptorship Rotation, Health Center Rotation,
Family Residency Program (1977)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: Kenneth Veit, D.O., Chairman
Division of Community Medicine
Philadelphia College of Osteopathic Medicine
Address: 4190 City Line Avenue
Philadelphia, PA 19131
Telephone: 215-581-6231

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Preceptorships

NARRATIVE DESCRIPTION:

The Philadelphia College of Osteopathic Medicine (PCOM) promotes the traditional goals of osteopathic medicine in encouraging physicians to practice primary care. At an undergraduate level, PCOM has a 4 week required preceptorship rotation for third-year students, and a 12-week required rotation to a health center for fourth-year students. The goal of these rotations is to provide students hands-on, clinical experience in primary care. The health center rotations take place at PCOM's four sites, located in HMSA-designated areas, or in two other sites not administered by PCOM located in rural Pennsylvania. PCOM also has a Residency Family practice with six residents. These programs are funded from PCOM's general budget.

GOALS: 1. Increase the number of physicians in primary care.
2. Attract physicians to underserved areas.

PARTICIPATING INSTITUTIONS: Osteopathic school, ambulatory clinics, hospitals, private practices.

CLINICAL SPECIALTIES: Primary care

AREA SELECTION CRITERIA: HMSA

STANDARDS FOR

PROGRAM EVALUATION: Number of graduates entering primary care

OUTCOME: 70 percent of graduates enter primary care fields

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$*</u>	<u>\$*</u>	<u>\$*</u>

* Funded from PCOM's general budget.

Pennsylvania

CURRENT SOURCE	FEDERAL:	0%
OF FUNDING:	STATE:	0%
(PERCENT)	LOCAL:	0%
	PRIVATE:	<u>100%</u>
	TOTAL:	100%

PARTICIPANT PROFILE:	1983	1984	1985
Total #	824*	824*	824*
% In-State Residents	81	81	81
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	69/31	69/31	69/31
% Minority	4	4	4

* Total number of students enrolled at PCOM.

Pennsylvania

PROGRAM (Date Initiated): Primary Care Preceptorship Programs, Family Practice Residency Consortium

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Thomas L. Leaman, M.D., Chairman
Dept. of Family and Community Medicine
Address: The Milton S. Hershey Medical Center
The Pennsylvania State University
Hershey, PA 17033
Telephone: 717-534-8736

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Preceptorships

NARRATIVE DESCRIPTION:

The Department of Family and Community Medicine attempts to address problems of physician maldistribution through several programmatic approaches, including a primarily rural focused preceptorship program. The elective program provides students the opportunity to gain some understanding of primary care. On average, from one-fourth to one-half of the 388 undergraduate medical students enroll in preceptorships, either a one-to-two-week period in the first or second year or a one-to-two-month experience in the fourth year or both. The majority are in rural or underserved areas, since one of the objectives of the program is to interest students in practicing in such areas upon completion of training. Since 1976 a formal agreement with Johns Hopkins University has brought 3-10 students a year from that institution's medical school into the Hershey preceptorship program.

GOALS:

1. Attract physicians to underserved rural areas.
2. Increase access to medical care in underserved rural areas.
3. Increase number of physicians in family practice.

PARTICIPATING INSTITUTIONS: Medical school, graduate medical training programs, hospitals, private practices

CLINICAL SPECIALTIES: Primary care

AREA SELECTION CRITERIA:

STANDARDS FOR PROGRAM EVALUATION: Preceptorship program is evaluated by utilizing questionnaires filled out by students and preceptors.

Pennsylvania

OUTCOME: Satisfaction is high.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$</u>	<u>\$</u>	<u>\$</u>

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 0%
LOCAL: 0%
PRIVATE: 0%
TOTAL: 0%

PARTICIPANT
PROFILE:

<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #		
% In-State Residents		
% Training/ Practicing in Rural Setting		
% Rural Origin		
% Male/Female		
% Minority		

Pennsylvania

PROGRAM (Date Initiated): Western Pennsylvania Health Preceptorship Program (1969)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Martin Seltman, M.D., Faculty Advisor
Address: M-200 Scufie Hall
University of Pittsburgh School of Medicine
Pittsburgh, PA 15261
Telephone: 412-624-2517

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Preceptorships

NARRATIVE DESCRIPTION:

The University of Pittsburgh School of Medicine offers two extracurricular preceptorship programs. First-year students may elect to spend eight weeks during the summer in a community hospital. The objectives of the experience are to expose students to clinical medicine in a community hospital setting; expose students to administrative aspects of operating a community hospital; and give students a perspective on illness within a community. Students receive stipends from the sponsoring hospitals.

Second-year students may elect an eight-week preceptorship in family practice with an individual physician or in a hospital's family practice residency program. Those students interning with individual physicians receive stipends from the University of Pittsburgh; those interning with hospitals receive stipends directly from the sponsoring hospital. Preceptors for second-year students receive faculty appointments at the University.

- GOALS:
1. Increase the number of physicians in primary care and family practice.
 2. Expose students to clinical practice.

PARTICIPATING INSTITUTIONS: Medical school, hospitals, practicing physicians

CLINICAL SPECIALTIES: Primary care, family practice.

AREA SELECTION CRITERIA:

STANDARDS FOR
PROGRAM EVALUATION:

OUTCOME:

Pennsylvania

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$59,540*	\$65,340**	\$72,620***

- * \$59,540 for first-year preceptorships; second year N/A.
 ** \$55,380 for first-year preceptorships; \$9,960 for second-year preceptorships.
 *** \$62,660 for first-year preceptorships; \$9,960 for second-year preceptorships.

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	12%
STATE:	0%
LOCAL:	0%
PRIVATE:	<u>88%</u>
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total # First Year	51	47	54
% In-State Residents	85	85	85
% Training/ Practicing in Rural Setting	<u>25</u>	<u>25</u>	<u>25</u>
% Rural Origin	<u></u>	<u></u>	<u></u>
% Male/Female	<u>70/30</u>	<u>70/30</u>	<u>70/30</u>
% Minority	<u></u>	<u></u>	<u></u>
Total # Second Year	6	10	10
% In-State Residents	85	85	85
% Training/ Practicing in Rural Setting	15	15	15
% Rural Origin	<u></u>	<u></u>	<u></u>
% Male/Female	70/30	70/30	70/30
% Minority	<u></u>	<u></u>	<u></u>

Pennsylvania

PROGRAM (Date Initiated): Gannon Program (1972)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: Dr. Bennett, Chairman of Family Medicine
Address: Hahnemann Medical College
230 N. Broad Street
Philadelphia, PA 19102
Telephone: 215-448-7604

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Other Curriculum Changes

NARRATIVE DESCRIPTION:

The Gannon Program is an agreement between Hahnemann University and Gannon College in which students attend three years of pre-medical college at Gannon in rural Pennsylvania and four years of medical school at Hahnemann, to receive both a BA and an M.D. in seven years. It is designed to decrease the shortage of primary care physicians in rural areas of the state by attracting rural students to medical school.

The program originally received start-up funds from the National Institutes of Health, but is now self-supporting; students pay their own way. Two-thirds of program graduates choose family medicine as a specialty, and many have remained in rural Pennsylvania.

- GOALS:
1. Encourage students from rural areas to attend medical school.
 2. Encourage students to enter primary care in rural areas.

PARTICIPATING INSTITUTIONS: Medical School, college

CLINICAL SPECIALTIES: Primary Care

AREA SELECTION CRITERIA:

STANDARDS FOR
PROGRAM EVALUATION: Number of participants entering primary care specialties and remaining in rural Pennsylvania

OUTCOME: Two-thirds choose primary care; many locate in rural Pennsylvania.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$0</u>	<u>\$0</u>	<u>\$0</u>

Pennsylvania

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 0%
LOCAL: 0%
PRIVATE: 0%
TOTAL: 0%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	10	10	10
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	<u> </u>	<u> </u>	<u> </u>
% Rural Origin	85	85	85
% Male/Female	<u> </u>	<u> </u>	<u> </u>
% Minority	<u> </u>	<u> </u>	<u> </u>

Pennsylvania

PROGRAM (Date Initiated): Student Loan Program (1948)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: LeRoy C. Erickson
Executive Director/Secretary
Address: The Educational and Scientific Trust of
the Pennsylvania Medical Society
20 Erford Road
Lemoyne, PA 17043
Telephone: 717-763-7151

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES:** Other Loans

NARRATIVE DESCRIPTION:

Since 1948, the Pennsylvania Medical Society has financed a low-interest loan program that assists state residents to secure medical education at any approved medical school in the United States. The goal of the loan program is to provide additional physicians to serve Pennsylvania, particularly as family physicians in rural locations and in other areas where physician shortages exist. The loan program is designed to meet deficits in students' budgets that remain after aid has been received from medical schools and the Pennsylvania Higher Education Assistance Agency. Loans are currently issued at a simple interest rate of 6 percent, and are due upon completion of graduate training (to a maximum of five years' of such training). The fund has provisions for students who are unable to immediately repay loans.

From time to time, The Educational and Scientific Trust will provide loans designed to finance entry into medical practice. These special loans vary in amount to a maximum of \$15,000; all carry a per annum interest rate of 10 percent. While each request is given individual consideration, preference is always given to physicians establishing their practices in medically underserved areas in Pennsylvania or in areas where a shortage of physicians is demonstrated.

The trust also has a loan fund designed to augment financial aid programs for certain auxiliary health professions, including physician assistants and professional nursing programs. Loans average \$1,000 per student per annum, carry a simple interest rate of 6 percent, and are due within 6 months of graduation.

- GOALS:
1. Increase the number of medical professionals in Pennsylvania.
 2. Assist state residents in securing medical education.

Pennsylvania

PARTICIPATING INSTITUTIONS: Medical education institutions, state and county medical societies.

ELIGIBILITY: State resident for at least one year prior to registration as medical student, intention to practice in state, financial need.

AREA SELECTION CRITERIA:

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ _____	\$ _____	\$1,500- \$2,500	\$ _____	4
<u>SERVICE OBLIGATION</u>			<u>BUYOUT PROVISIONS</u>	

STANDARDS FOR
PROGRAM EVALUATION: Default/delinquency rate.

OUTCOME: Currently, 2.7 percent of students are delinquent.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$392,400	\$477,225	\$405,250

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	0%
LOCAL:	0%
PRIVATE:	100%
TOTAL:	100%

<u>PARTICIPANT PROFILE:</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	183*	333**	275***
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

* 130 medical, 53 allied
** 267 medical, 66 allied
*** 232 medical, 43 allied

RHODE ISLAND
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
	X			-						

X = Presence of program.
+ = Program added since 1981.
- = Program discontinued since 1981.

Rhode Island

PROGRAM (Date Initiated): Rhode Island Health Professions Contract Program
(1965)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Marilyn P. Horman, Ed.D.
Special Programs Analyst
Address: Rhode Island Higher Education Assistance
Authority
274 Weybosset Street
Providence, RI 02903
Telephone: 401-277-2050

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Seat Purchase

NARRATIVE DESCRIPTION:

The state of Rhode Island has agreements with the University of Vermont College of Medicine (UVM) and the New England College of Osteopathic Medicine (NECOM) to reserve seats at capitated rates for Rhode Island residents. Currently, there are five new spaces per year at UVM and four new spaces per year at NECOM reserved for Rhode Island residents.

Students entering before 1985 had the option of a service obligation in return for loan forgiveness. Beginning in 1985, this option has been eliminated, due to budget constraints. Private funds were used in 1985 to continue the program. Students now use HEAL loans to repay the state for their seat purchase amount.

GOALS:

1. Secure spaces for state residents in medical and osteopathic programs.
2. Retain medical graduates within the state.

PARTICIPATING INSTITUTIONS: Medical school, osteopathic school

ELIGIBILITY: State resident, acceptance to participating school, financial need

AREA SELECTION CRITERIA:

Rhode Island

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ 12,500	\$13,450	\$13,450 for UVM; 12,500 for NECOM	\$13,450	4

SERVICE OBLIGATION
None beginning in 1985;
previously 75% cancella-
tion allowed if work for
the state for 3 years and
25% cancellation if work
in the state for 3 years

BUYOUT PROVISIONS
Borrower has right to
prepay the whole or any
portion of loan without
penalty.

STANDARDS FOR
PROGRAM EVALUATION:

OUTCOME:

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$494,813	\$334,400	\$301,660*

CURRENT SOURCE
OF FUNDING:*
(PERCENT)

FEDERAL: 0%
STATE: 0%
LOCAL: 0%
PRIVATE: 100%
TOTAL: 100%

PARTICIPANT PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985*</u>
Total #	59	39	29
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

* This year was an unusual year, in which private funds were used to continue the program.

SOUTH CAROLINA
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
				X			X			X

X = Presence of program.
+ = Program added since 1981.
- = Program discontinued since 1981.

324

325

South Carolina

South Carolina

PROGRAM (Date Initiated): South Carolina Medical and Dental Loan Fund
(1974)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Douglas E. Bryant, Director
Address: Office of Primary Care
South Carolina Department of Health and
Environmental Control
2600 Bull Street
Columbia, SC 29201
Telephone: 803-758-4664

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES:** Service-contingent Loans and
Scholarships

NARRATIVE DESCRIPTION:

The South Carolina Medical and Dental Loan Fund provides loans to state residents attending medical and dental schools. The program has a forgiveness clause for recipients who agree to practice in a program-defined shortage area for one year for each year of assistance to a maximum of three years' of service. The penalty for failure to fulfill the service obligation is 300 percent of principal and interest at the prevailing prime rate. Almost all participants fulfill their obligations.

GOALS:

1. Attract physicians and dentists to underserved areas.
2. Reduce financial barriers for state residents attending medical and dental school.
3. Retain state medical and dental graduates within the state.

PARTICIPATING INSTITUTIONS: Medical and Dental Schools

ELIGIBILITY: State resident, financial need, commitment to practice in an underserved area of the state, acceptance into accredited medical or dental school

AREA SELECTION CRITERIA: Physician: Population < 1:2000
Dentist :Population < 1:6000

South Carolina

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ None	\$10,000	\$10,000	\$ None	4
<u>SERVICE OBLIGATION</u>		<u>BUYOUT PROVISIONS</u>		
One year in underserved area for each year of aid, for a maximum of 3 years.		300% of principal and interest at prevailing prime rate, payable within 10 years.		

STANDARDS FOR

PROGRAM EVALUATION:

Number of professionals continuing to practice in area of need after completing obligation.

OUTCOME: Almost all participants fulfill their obligations: approximately 20 percent of participants continue to practice in areas of highest need; another 28 percent practice in areas of average need; the remainder practice in areas of least need as measured by the state.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$279,000	\$279,000	\$279,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	32	33	34
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			83/17
% Minority			21

South Carolina

PROGRAM (Date Initiated): South Carolina Consortium of Community Teaching Hospitals; Medical University of South Carolina Recruitment, Retention and Placement Program (1984)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: John Watkins, Director
Address: Division of Recruitment, Retention and Placement
Medical University of South Carolina
171 Ashley Avenue
Charleston, SC 29425
Telephone: 803-792-4431

TYPE OF INCENTIVE: AID IN PRACTICE: Placement

NARRATIVE DESCRIPTION:

The Recruitment, Retention and Placement Program was established in 1984 under the auspices of the South Carolina Consortium of Community Teaching Hospitals to match graduating residents and physicians with communities (particularly rural), thus increasing the accessibility of medical care in rural South Carolina. The Office currently has a computer listing of over 300 practice opportunities in the state. Representatives of the program visit with medical residents and practitioners throughout the state. The list of practice opportunities is updated bimonthly and a hard copy forwarded to each program and to residents upon request. The practice opportunities list is also forwarded to alumni of each medical school upon request. The program, funded by the state, has established an effective demand model that utilizes physicians, hospital administrators, and communities to create a current computer listing of South Carolina practice opportunities. Because the program is still in its infancy, true results of its success cannot be formally measured.

GOALS:

1. Retention of graduating residents.
2. Match physicians with communities (particularly rural) in need.

PARTICIPATING INSTITUTIONS: Medical schools, graduate medical training programs, practicing physicians, AHECs

CLINICAL SPECIALTIES: None specified.

AREA SELECTION CRITERIA:

STANDARDS FOR
PROGRAM EVALUATION: Placement success rate

OUTCOME: Too early for outcomes

South Carolina

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$ 0</u>	<u>\$ 0</u>	<u>\$65,000*</u>

* This was the first year of operation

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 100%
LOCAL: 0%
PRIVATE: 0%
TOTAL: 100%

NOT RELEVANT TO THIS PROGRAM

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	<u> </u>	<u> </u>	<u> </u>
% In-State Residents	<u> </u>	<u> </u>	<u> </u>
% Training/ Practicing in Rural Setting	<u> </u>	<u> </u>	<u> </u>
% Rural Origin	<u> </u>	<u> </u>	<u> </u>
% Male/Female	<u> </u>	<u> </u>	<u> </u>
% Minority	<u> </u>	<u> </u>	<u> </u>

South Carolina

PROGRAM (Date Initiated): South Carolina AHEC Program (1972)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Henry W. Koelling, Jr., M.B.A., Administrator
Address: South Carolina AHEC
Medical University of South Carolina
171 Ashley Avenue
Charleston, SC 29425
Telephone: 803-792-4431

TYPE OF INCENTIVE: AID IN PRACTICE: AHECs

NARRATIVE DESCRIPTION:

The South Carolina AHEC was initiated in 1972 for the purpose of providing graduate medical education and continuing medical education in underserved areas. The program initially received federal funds but is currently funded by state and local sources at an annual rate of \$25.3 million. The AHEC has seven sites throughout the state, and is administered under the auspices of the statewide consortium of Teaching Hospitals.

- GOALS:
1. Encourage physicians to locate in underserved areas.
 2. Improve access to care in underserved areas.

PARTICIPATING INSTITUTIONS: Health practitioners and institutions throughout the state

CLINICAL SPECIALTIES: All primary care

AREA SELECTION CRITERIA: HMSA

STANDARDS FOR
PROGRAM EVALUATION: Manpower distribution

OUTCOME: Marked improvements over life of the program

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$25,300,000	\$25,300,000	\$25,300,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	53%
LOCAL:	47%
PRIVATE:	0%
TOTAL:	100%

South Carolina

NOT RELEVANT TO THIS PROGRAM

PARTICIPANT
PROFILE:

	1983	1984	1985
Total #			
% In-State Residents			
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

SOUTH DAKOTA
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
				-						

X = Presence of program.
+ = Program added since 1981.
- = Program discontinued since 1981.

TENNESSEE
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
		X								+

X = Presence of program.
+ = Program added since 1981.
- = Program discontinued since 1981.

Tennessee

PROGRAM (Date Initiated): Appalachian Student Health Coalition (1976)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: Ben Leo & Hayward Wilkerson, Co-Directors
Appalachian Student Health Coalition
Center for Health Services

Address: Vanderbilt University
Nashville, TN 37232

Telephone: 615-322-4773

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Preceptorships

NARRATIVE DESCRIPTION:

The Appalachian Student Health Coalition was founded in 1968 by a group of medical students from Vanderbilt University and Meharry Medical College. Students, faculty, and concerned citizens joined together to provide free physical examinations and in-home follow-up services to people in medically underserved areas. Since 1968 the Coalition has been working throughout the Appalachian region and west Tennessee to alleviate problems caused by an inadequate supply of health care providers and a poor distribution of medical facilities. The program is funded by several private foundations.

Through the program, students spend a summer in internships in local communities, where they coordinate health fairs and other activities designed to increase health awareness. All students receive stipends of \$100-135 per week and room and board are provided by local families.

GOALS:

1. Increase access to and awareness of health care in underserved areas.
2. Give students hands-on experience in rural areas.

PARTICIPATING INSTITUTIONS: Medical schools, graduate medical training programs, practitioners and health institutions in the state

CLINICAL SPECIALTIES:

AREA SELECTION CRITERIA:

**STANDARDS FOR
PROGRAM EVALUATION:**

OUTCOME: None specified.

Tennessee

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$75,760	\$75,030	\$55,250

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 0%
LOCAL: 0%
PRIVATE: 100%
TOTAL: 100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	35	31	27
% In-State Residents			
% Training/ Practicing in Rural Setting	100	100	100
% Rural Origin			
% Male/Female			
% Minority			

Tennessee

PROGRAM (Date Initiated): Middle Tennessee AHEC (1984)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: Edwina E. H. Hamby, Associate Director
Middle Tennessee AHEC
Meharry Medical College, School of Medicine
Address: 1005 Dr. D.B. Todd, Jr. Blvd.
Nashville, TN 37208
Telephone: 615-327-6834

TYPE OF INCENTIVE: AID IN PRACTICE: AHECs

NARRATIVE DESCRIPTION:

The Middle Tennessee AHEC program is currently in its second year of funding; the first year was devoted to program planning; 1985-1986 was the first year of operation. The AHEC program has one central site and 64 participating sites. Program activities include continuing medical education, training in patient health and education, recruitment and relocation of health professionals, and cooperative arrangements with health professions training programs to establish preceptorships and clerkships for students. The program is directed towards all health professions, ranging from physicians to allied health professionals.

- GOALS:
1. Attract health professionals to underserved areas.
 2. Increase access in underserved areas.
 3. Balance provider supply with demand.

PARTICIPATING INSTITUTIONS: Health institutions throughout the state.

CLINICAL SPECIALTIES:

AREA SELECTION CRITERIA: HMSA

STANDARDS FOR
PROGRAM EVALUATION:

OUTCOME: Too early for outcomes

ANNUAL FUNDING LEVELS:	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	<u>\$ 0</u>	\$186,800*	\$328,642*

* Federal funding level.

Tennessee

CURRENT SOURCE	FEDERAL:	75%
OF FUNDING:	STATE:	0%
(PERCENT)	LOCAL:	25%
	PRIVATE:	100%
	TOTAL:	100%

NOT RELEVANT TO THIS PROGRAM

PARTICIPANT PROFILE:	1983	1984	1985
Total #			
% In-State Residents			
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

TEXAS
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
X				X	X		-			

X = Presence of program.
+ = Program added since 1981.
- = Program discontinued since 1981.

Texas

PROGRAM (Date Initiated): Family Practice Residency Program (1977)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: John Cobb, Director, Financial Planning
Address: Coordinating Board
Texas College and University System
P. O. Box 12788
Austin, TX 78711
Telephone: 512-462-6462

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Primary Care Residencies

NARRATIVE DESCRIPTION:

Under the Family Practice Residency Program, the Coordinating Board of the Texas College and University System contracts with medical schools, licensed hospitals, or nonprofit corporations for the establishment and compensation of approved family practice residencies. Compensation is made on a formula approved by the Board based upon the number of resident physicians in the training program. The program also runs a preceptorship program for undergraduate medical students.

Over the life of the program, 80 percent of participants have remained in Texas; approximately 95 percent practice in communities with fewer than 25,000 population.

- GOALS:
1. Increase the number of physicians in primary care and/or family practice.
 2. Increase access to medical care in underserved urban and rural areas.
 3. Attract physicians to underserved urban and rural areas.

PARTICIPATING INSTITUTIONS: Medical schools, graduate medical training programs, hospitals.

CLINICAL SPECIALTIES: Family practice

AREA SELECTION CRITERIA:

STANDARDS FOR

PROGRAM EVALUATION: Percentage of graduates locating in underserved areas.

OUTCOME: Over the life of the program 80.4% of residents are practicing in Texas. Of those, 22.2% are in a community of fewer than 10,000 population, 72.7% in a community between 10,000-25,000 population and 5.1% in a community between 25,000-50,000 population.

Texas

ANNUAL FUNDING LEVELS:	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	\$30,100,000	\$31,250,000	\$34,400,000
CURRENT SOURCE OF FUNDING: (PERCENT)	FEDERAL: 1% STATE: 41%* LOCAL: 5%** PRIVATE: <u>53%</u> TOTAL: 100%		

* State includes funds from state-supported medical schools.

** Private includes support from affiliated hospitals and patient revenue.

PARTICIPANT PROFILE:	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	435	459	466
% In-State Residents	_____	_____	_____
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

Texas

PROGRAM (Date Initiated): Physician Student Loan Repayment Program (1985)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Mack Adams, Assistant Commissioner for Student Services

Address: Texas College and University System
P.O. Box 12788 Capital Station
Austin, TX 78711

Telephone: 512-462-6325

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES:** Service-contingent Loans and Scholarships

NARRATIVE DESCRIPTION:

The Physician Student Loan Repayment Program provides for the repayment of outstanding graduate and professional student loans for Texas physicians practicing in economically depressed and medically underserved areas of Texas or for the Texas Department of Health, the Texas Department of Mental Health and Mental Retardation, the Texas Department of Corrections or the Texas Youth Council. Eligible physicians may qualify for the repayment of up to \$3,000 per year for practicing in the area or state agencies named above.

GOALS: 1. Attract physicians to underserved areas and state institutions.

PARTICIPATING INSTITUTIONS:

ELIGIBILITY: Priority given to renewal applicants and Texas residents.

AREA SELECTION CRITERIA: HMSA Modification: HMSA or state institution.

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ None	\$ 3,000	\$	\$15,000	5

SERVICE OBLIGATION

BUYOUT PROVISIONS

Optional service in underserved area or state agency. Repayment of up to \$3,000 for each year of service.

Texas

STANDARDS FOR
PROGRAM EVALUATION: None.

OUTCOME:

ANNUAL FUNDING LEVELS:*	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
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* New program; legislature has appropriated \$99,660 for fiscal year 1986 and \$333,000 for fiscal year 1987.

CURRENT SOURCE OF FUNDING: (PERCENT)	FEDERAL: 0%
	STATE: 100%
	LOCAL: 0%
	PRIVATE: <u> % </u>
	TOTAL: 100%

PARTICIPANT PROFILE:*	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	<u> </u>	<u> </u>	<u> </u>
% In-State Residents	<u> </u>	<u> </u>	<u> </u>
% Training/ Practicing in Rural Setting	<u> </u>	<u> </u>	<u> </u>
% Rural Origin	<u> </u>	<u> </u>	<u> </u>
% Male/Female	<u> </u>	<u> </u>	<u> </u>
% Minority	<u> </u>	<u> </u>	<u> </u>

* New program; data not yet available.

Texas

PROGRAM (Date Initiated): State Rural Medical Education Board Loans (1975)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Duane Keeran, Director
Address: State Rural Medical Education Board
211 East 7th Street
Southwest Tower Building
Austin, TX 78701
Telephone: 512-463-5501

TYPE OF INCENTIVE: FINANCIAL INCENTIVES: Service-contingent Loans and Scholarships

NARRATIVE DESCRIPTION:

The Texas Rural Medical Education Board provides assistance to Texas residents to finance their medical education in return for an agreement to practice in a rural area upon completion of residency training. Twenty percent of the loan is forgiven for each year of practice in a rural area (defined as a community of fewer than 30,000 population). There is a penalty for default of 100 percent of the principal plus accrued interest in addition to the loan payment. The default penalty is waived if the physician has practiced in a rural area for a minimum of two years, but principal and interest must be repaid for service of less than five years.

GOALS: 1. Financial assistance to medical students who wish to practice in rural areas.

PARTICIPATING INSTITUTIONS: Medical school

ELIGIBILITY: State resident, financial need, commitment to practice in a rural area, acceptance into medical school.

AREA SELECTION CRITERIA: Community size: Population fewer than 30,000.

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
<u>\$</u>	<u>\$</u>	<u>\$4,500</u>	<u></u>	<u>4</u>

SERVICE OBLIGATION

One year of service in a rural area of fewer than 30,000 population cancels 20% of the loan. Five years' of service cancels the entire loan.

BUYOUT PROVISIONS

For service between 2-5 years, repayment of the remainder of the loan at 10% interest over 2 years. For service less than 2 years, repayment of the loan at 10% interest plus a penalty of 100% principal plus accrued interest.

STANDARDS FOR

PROGRAM EVALUATION:

The number of physicians who serve in a rural area.
The number of physicians who repay the loan.

OUTCOME:

As of March 1986, the total number of residents and physicians who have or are currently in the process of repaying their obligations in cash instead of services is 50, or 23% of total participants.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$629,000</u>	<u>\$635,000</u>	<u>\$630,000</u>

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 100%
LOCAL: 0%
PRIVATE: 0%
TOTAL: 100%

PARTICIPANT PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	<u>160</u>	<u>176</u>	<u>166</u>
% In-State Residents	100	100	100
% Training/Practicing in Rural Setting	38*	38*	38*
% Rural Origin	64*	64*	64*
% Male/Female	76/24*	76/24*	76/24*
% Minority	24*	24*	24*

* Percentages were given over the life of the program and were not available on a yearly basis.

** Participants responding to a questionnaire in January 1986 who had lived in a county with population less than 30,000 for one or more years prior to entering medical school. 278 participants responded to the questionnaire.

Texas

PROGRAM (Date Initiated): Valley Family Physician Scholarship Fund (1975)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: Suzanne Anderson, Loan Administrator
Address: Texas Medical Association
1801 N. Lamar Blvd.
Austin, TX 78701
Telephone: 512-477-6704

TYPE OF INCENTIVE: FINANCIAL INCENTIVES: Other Loans

NARRATIVE DESCRIPTION:

The Valley Family Physician Scholarship Fund was established to provide low-interest loans for undergraduate medical education to qualified financially needy residents of ten counties in the state who intend to enter family practice. Repayment of the loan begins four years after graduation from medical school and must be completed within a four-year period.

GOALS:

1. Reduce financial barriers to medical training for state residents.
2. Increase the number of physicians in family practice.
3. Promote medical career opportunities for the economically disadvantaged or other minority groups.

PARTICIPATING INSTITUTIONS: Medical school.

ELIGIBILITY: U.S. Citizen; resident of one of ten medically underserved counties in Texas; financial need; intent to enter family practice.

AREA SELECTION CRITERIA:

CONDITIONS:

<u>MINIMUM</u> <u>ANNUAL AWARD</u>	<u>MAXIMUM</u> <u>ANNUAL AWARD</u>	<u>AVERAGE</u> <u>AWARD</u>	<u>OVERALL</u> <u>MAXIMUM</u> <u>AWARD</u>	<u>MAXIMUM</u> <u>YEARS</u> <u>OF AID</u>
\$ _____	\$2,000	\$2,000	\$8,000	4
<u>SERVICE OBLIGATION</u>			<u>BUYOUT PROVISIONS</u>	
_____			_____	

Texas

STANDARDS FOR
PROGRAM EVALUATION: The number of loans in default.

OUTCOME: There have been no loan defaults.

ANNUAL FUNDING LEVELS:	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	\$5,000	\$3,000	\$8,000
CURRENT SOURCE OF FUNDING: (PERCENT)	FEDERAL: 0% STATE: 0% LOCAL: 0% PRIVATE: <u>100%</u> TOTAL: 100%		
PARTICIPANT PROFILE:	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	3	2	4
% In-State Residents	3	2	4
% Training/ Practicing in Rural Setting			
% Rural Origin	3	2	4
% Male/Female	67/33	50/50	25/75
% Minority	33	50	75

UTAH
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
							X			

- X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

Utah

PROGRAM (Date Initiated): CompHealth

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: Therus C. Kolff, M.D., President

Address (Two Offices): COMPHEALTH

175 W. 200 Street, Suite 2003

Salt Lake City, UT 84101

Telephone: 801-532-1200/1-800-453-3030

Address: 5901 Peachtree Dunwoody Road, Suite C-65

Atlanta, GA 30328

Telephone: 404-391-9876/1-800-354-4050

TYPE OF INCENTIVE: AID IN PRACTICE: Placement

NARRATIVE DESCRIPTION:

Comprehensive Health Systems is a Utah-based recruitment and placement organization which provides national locum tenens physician services. A geographically diverse group of physicians representing primary care and all other specialties are temporarily matched to individual practices during physician leaves due to vacation, continuing medical education or for any other reason. CompHealth arranges hospital privileges and coordinates travel and housing as well as paying the physician's salary, malpractice insurance and licensure costs. CompHealth has also utilized a locum tenens approach in placing physicians in underserved areas on a permanent basis.

GOALS:

1. Match physicians to communities in need.
2. Provide a temporary service for physicians.

PARTICIPATING INSTITUTIONS: Hospitals, group practices, private practices - in all states.

CLINICAL SPECIALTIES: All

AREA SELECTION CRITERIA:

STANDARDS FOR

PROGRAM EVALUATION: Quality of care and having the group asked for repeat coverage during next physician absence.

OUTCOME: None

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$</u>	<u>\$</u>	<u>\$</u>

Utah

CURRENT SOURCE	FEDERAL:	0%
OF FUNDING:	STATE:	0%
(PERCENT)	LOCAL:	0%
	PRIVATE:	100%
	TOTAL:	100%

NOT RELEVANT TO THIS PROGRAM

PARTICIPANT PROFILE:	1983	1984	1985
Total #			
% In-State Residents			
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

VIRGINIA
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
				X			X			X

X = Presence of program.
+ = Program added since 1981.
- = Program discontinued since 1981.

Virginia

PROGRAM (Date Initiated): Virginia State Medical Scholarship Program
(1943)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Sally Camp, Staff Assistant
Address: Department of Health

Commonwealth of Virginia

109 Governor Street

Richmond, VA 23219

Telephone: 804-786-3561

TYPE OF INCENTIVE: FINANCIAL INCENTIVES: Service-contingent Loans and
Scholarships

NARRATIVE DESCRIPTION:

The Virginia State Medical Scholarship Program offers scholarships to state resident medical and dental students in return for a commitment to practice in areas of need in Virginia in specified primary care disciplines. Osteopathic students are eligible for scholarship funds but to date none have participated in the program. This is attributable to the absence of a college of osteopathic medicine in Virginia.

- GOALS:
1. Increase access to underserved urban and rural areas.
 2. Attract physicians to underserved urban and rural areas.
 3. Balance physician supply with demand.

PARTICIPATING INSTITUTIONS: Medical school

ELIGIBILITY: Commitment to practice in shortage area, commitment to practice in the state, enrollment in Virginia medical or dental school

AREA SELECTION CRITERIA: Other: approval on a case-by-case basis.

Virginia

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
<u>\$ None</u>	<u>\$2,500</u>	<u>\$2,500</u>	<u>\$10,000</u>	<u>4</u>
<u>SERVICE OBLIGATION</u>		<u>BUYOUT PROVISIONS</u>		
One year in shortage area for each year of scholar- ship		Principal + prevailing interest, payable within 10 years		

STANDARDS FOR

PROGRAM EVALUATION: Number of participants fulfilling service obligation.

OUTCOME: Between 1974 and 1979, approximately 47% of medical and dental students fulfilled their service obligations.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$</u>	<u>\$</u>	<u>\$</u>

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 100%
LOCAL: 0%
PRIVATE: 0%
TOTAL: 100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	80	80	80
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

Virginia

PROGRAM (Date Initiated): Physician Referral Service (1950)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: Bill Bates
Address: Virginia Health Council, Inc.
3312 W. Cary Street
Richmond, VA 23221
Telephone: 804-358-9944

TYPE OF INCENTIVE: AID IN PRACTICE: Placement

NARRATIVE DESCRIPTION:

The Virginia Health Council is a nonprofit organization which keeps a listing of opportunities for physicians, dentists, dental hygienists, and occupational therapists. The listing is compiled through telephone and written inquiries that the council receives from communities and practices throughout the state.

GOALS: 1. Match physicians, dentists, nurses with communities in need.

PARTICIPATING INSTITUTIONS: Practitioners and communities throughout Virginia.

CLINICAL SPECIALTIES:

AREA SELECTION CRITERIA:

STANDARDS FOR
PROGRAM EVALUATION:

OUTCOME:

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
<u>\$75,000</u>	<u>\$75,000</u>	<u>\$75,000</u>

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	0%
LOCAL:	0%
PRIVATE:	100%
TOTAL:	100%

Virginia

NOT RELEVANT TO THIS PROGRAM

PARTICIPANT
PROFILE:

	1983	1984	1985
Total #			
% In-State Residents			
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

Virginia

PROGRAM (Date Initiated): Eastern Virginia AHEC (1979)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: Edward G. Haskell, Jr., M.D., Director
Eastern Virginia AHEC

Address: Eastern Virginia Medical School
P. O. Box 1980
Norfolk, VA 23501

Telephone: 804-446-5972

TYPE OF INCENTIVE: AID IN PRACTICE: AHECs

NARRATIVE DESCRIPTION:

Eastern Virginia AHEC is a regional AHEC which focuses on both rural and urban underserved areas. The AHEC is a consortium of three medical schools, three nursing schools, two allied health sciences schools, and one school of social work. The consortium has three community AHEC sites in eastern Virginia. The primary focus of AHEC activities is on undergraduate and graduate medical, nursing and allied health professions education. Undergraduate medical students take rotations in their second, third, and fourth years to AHEC sites and other community clinics. Graduate medical students take structured rotations to inner city clinics and AHEC sites. The AHEC has a particular focus on migrant health issues, since 5,000-6,000 migrants pass through the Tidewater region each year. To address these issues, the AHEC sponsors interdisciplinary programs, to coordinate the efforts of physicians, nurse practitioners, dentists and others to serve the migrant population. Eastern Virginia AHEC does not provide continuing medical education to physicians because of EVAMEC, another organization with the medical school, already carries out these programs. Finally, the AHEC does some staff developments at local hospitals, provides continuing education for allied health professionals, and provides informal physician placement assistance, particularly for NHSC physicians seeking placements.

The AHEC activities are funded with federal funds, in conjunction with in-kind contributions from faculty members and communities.

GOALS:

1. Increase the supply of primary care practitioners to medically underserved areas.
2. Enhance the practice environment of health professionals in medically underserved areas to attract and retain health care personnel.
3. Strengthen the interaction between educational health science institutions and the health care community.

Virginia

PARTICIPATING INSTITUTIONS: Medical schools, nursing schools, allied health and social work schools, AHEC sites.

CLINICAL SPECIALTIES: Primary care.

AREA SELECTION CRITERIA: HMSA

STANDARDS FOR
PROGRAM EVALUATION: Number of student placements, continuing medical education programs, and the ability of the program to meet its slated goals.

OUTCOME: During the first 5 years, the EVHAC Program facilitated more than 6,500 student placements in 15 health science disciplines. These placements reflect a 1,059% increase from PY2 to PY5, from 260 to 3,013 placements. They include diverse and innovative rotations in an inner city hospital, a family-centered public health clinic, health risk reduction education delivered in public school classrooms, and health care to migrant farmworkers. Many of these experiences are interdisciplinary, allowing students broader perspectives of the health delivery system than their single disciplines permit. The increase in number of training sites, from 41 sites in PY2 to 134 in PY5, attests to the successful regionalization of health professions education throughout Hampton Roads.

In addition to supporting undergraduate and graduate health professions education, the AHEC facilitated continuing education for 4,705 health practitioners through PY5, including many who otherwise had no such access. Rapid growth was experienced at this level of education as well, from 325 placements in PY2 to 2,278 placements in PY5, an increase of 600%. Continuing education services ranged from practice management consultations for individual physicians to semester-long courses for pharmacists.

ANNUAL FUNDING LEVELS:	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	\$1,200,000	\$1,200,000	\$1,100,000

* This does not reflect local and in-kind contributions.

CURRENT SOURCE	FEDERAL:	100%
OF FUNDING:	STATE:	0%
(PERCENT)	LOCAL:	0%
	PRIVATE:	0%
	TOTAL:	100%

Virginia

NOT RELEVANT TO THIS PROGRAM

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	<u> </u>	<u> </u>	<u> </u>
% In-State Residents	<u> </u>	<u> </u>	<u> </u>
% Training/ Practicing in Rural Setting	<u> </u>	<u> </u>	<u> </u>
% Rural Origin	<u> </u>	<u> </u>	<u> </u>
% Male/Female	<u> </u>	<u> </u>	<u> </u>
% Minority	<u> </u>	<u> </u>	<u> </u>

WASHINGTON
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
X	X			X			-			

X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

Washington

PROGRAM (Date Initiated): Washington, Alaska, Montana, Idaho (WAMI) (1971)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Wayne W. Myers, M.D.
Associate Dean for Regional Affairs
Director, WAMI Program
Address: School of Medicine, SC-64
University of Washington
Seattle, WA 98195
Telephone: 206-545-2491

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Seat Purchase

NARRATIVE DESCRIPTION:

WAMI is a program at the University of Washington, the only medical school in the four-state area. Its purpose is to train more primary care doctors and encourage them to practice in rural, underserved areas. Students from the participating states enroll at the University of Washington School of Medicine but take basic science courses on their "home" campuses (e.g., Washington State University) for their first year. After the first year, they move to the Seattle campus. In the third and fourth years, students take required clerkships in family medicine, pediatrics, obstetrics and gynecology, and psychiatry either in traditional teaching hospitals in Seattle or in 17 "community clinical units" scattered across the four participating states.

The WAMI program is more oriented to resource sharing than to tuition reciprocity. The states bear their shares of costs and in return benefit from the increased availability of physicians without the costs of constructing medical schools. Washington residents gain from the effects of the shared costs and increased opportunities for clinical education.

The program is designed to provide exposure to medical practice outside of metropolitan areas. WAMI students choose Family Practice at a rate of about two to one over other students in the medical program.

GOALS:

1. Consolidate University of Washington School of Medicine as the medical school for four states.
2. Encourage students to enter primary care specialties.
3. Improve geographic distribution of physicians; balance physician supply with demand.

Washington

PARTICIPATING INSTITUTIONS: Medical school, universities.

CLINICAL SPECIALTIES:

AREA SELECTION CRITERIA:

STANDARDS FOR

PROGRAM EVALUATION: Number of students entering primary care specialties; performance of WAMI students compared to Washington state students. Number of graduates entering non-metropolitan practice.

OUTCOME: WAMI students choose family practice at a rate of about 2 to 1 over medical students nationally; common examinations are given to first-year students at all 5 WAMI sites; the WAMI students consistently perform as well as the Washington state students. WAMI graduates 1975-1979: 30% are now practicing in non-metropolitan areas; 66% are now practicing in primary care (family medicine, general internal medicine, general pediatrics); 24% are now practicing primary care in non-metropolitan areas.

ANNUAL FUNDING
LEVELS:

<u>FY 1983*</u>	<u>FY 1984*</u>	<u>FY 1985*</u>
\$3,896,279**	\$4,139,471**	\$4,474,474**

* Academic years 1982-83, 1983-84, 1984-85.

** This figure represents payments by Alaska, Montana, and Idaho to the University of Washington for the WAMI program. Does not include payments by Washington state residents, since tuition payments by state residents go directly into the state General Fund.

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
	WA AK ID MT	WA AK ID MT	WA AD ID MT
Total #	460 40 80 80	460 43 79 80	460 48 77 80
% In-State Residents	100	100	100
% Training/Practicing in Rural Setting	40% of 1st-year class 25% of 3rd-year class		
% Rural Origin	33	33	33
% Male/Female	71/29	68/32	67/33
% Minority			

Washington

PROGRAM (Date Initiated): University of Washington Affiliated Family Practice Residency Network (1974)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: Ronald Schneeweiss, M.D., Coordinator
Address: Department of Family Medicine HQ-13
University of Washington
Seattle, WA 98195
Telephone: 206-545-1856

TYPE OF INCENTIVE: EXPERIENCES DURING EDUCATION: Primary Care Residencies

NARRATIVE DESCRIPTION:

The University of Washington Affiliated Family Practice Resident Network is a statewide program designed to provide varied settings to train family practice physicians. Participating affiliates address such common needs as curriculum development, program evaluation, problem solving of operational and funding problems and coordination of resident rotations and electives.

Of program participants, 41 percent are currently practicing in communities of 50,000 or fewer population.

GOALS:

1. Increase the number of physicians in primary care and/or family practice.
2. Coordinate resources between medical school and community hospitals.
3. Achieve a balance of physician supply with projected need or demand for medical care.

PARTICIPATING INSTITUTIONS: Medical school, graduate medical training program, college, hospital, ambulatory care facility, group practice, private practice.

CLINICAL SPECIALTIES: Family practice

AREA SELECTION CRITERIA:

STANDARDS FOR
PROGRAM EVALUATION: Retention of physicians in the state; placement of physicians in rural areas.

OUTCOME: 68% are practicing in Washington; 41% are practicing in communities of 50,000 or less.

Washington

ANNUAL FUNDING LEVELS:	<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
	\$7,064,574	\$7,579,515	\$8,691,998
CURRENT SOURCE OF FUNDING: (PERCENT)	FEDERAL: 6% STATE: 15% LOCAL: 0% PRIVATE: 79% TOTAL: 100%		
PARTICIPANT PROFILE:	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	128*	104*	122*
% In-State Residents	86	83	84
% Training/ Practicing in Rural Setting	55**	56**	41**
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

* Not including those in the military, who do not receive funding.

** Based on locations of all graduates in communities of 50,000 or fewer.

Washington

PROGRAM (Date Initiated): Student Loan Fund (1969)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: Warren Lawless, Executive Vice President
Address: Washington Osteopathic Foundation
4210 S.W. Oregon Street
Seattle, WA 98116
Telephone: 206-937-5358

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES:** Service-contingent Loans and Scholarships

NARRATIVE DESCRIPTION:

The Student Loan Fund of the Washington Osteopathic Association provides low-interest loans to Washington state residents attending osteopathic school in return for an agreement to repay the loan, to practice in the state of Washington for three years, and to be a member of the Washington Osteopathic Association during that time. The objective of the fund is to encourage Washington residents attending osteopathic school to return to the state (Washington does not have an osteopathic school).

GOALS: 1. Encourage Washington residents attending osteopathic school to practice in the state.

PARTICIPATING INSTITUTIONS: Osteopathic schools

ELIGIBILITY: State resident, financial need, have attended osteopathic school for at least one semester or quarter.

AREA SELECTION CRITERIA: Anywhere in the state.

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ None	\$2,000	\$1,000	\$ None	4

SERVICE OBLIGATION

Practice in the state for 3 years in addition to repayment of loan at 8% interest over 2-year period.

BUYOUT PROVISIONS

Principal + 18% interest accruing from date of loan agreement, payable immediately.

Washington

STANDARDS FOR
PROGRAM EVALUATION: Number of participants fulfilling service obligations.

OUTCOME: Very few students fail to fulfill service obligations.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$8,000	\$10,000	\$12,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL: 0%
STATE: 0%
LOCAL: 0%
PRIVATE: 100%
TOTAL: 100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	4	5	6
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	50/50	60/40	83/17
% Minority	_____	_____	_____

WEST VIRGINIA
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
				X						X

X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

West Virginia

PROGRAM (Date Initiated): West Virginia State Medical Association Loan Program (1986 est)

ADMINISTRATIVE LOCUS: Private

ADMINISTRATOR:

Director/Contact Person: Student Financial Aid Director, West Virginia University School of Medicine

Address: 2008 Basic Sciences
Morgantown, WV 26506

Telephone: 304-293-3706

Director/Contact Person: Student Financial Aid Director, Marshall University School of Medicine

Address: Old Main
Charleston, WV 25701

Telephone: 304-696-3162

TYPE OF INCENTIVE: FINANCIAL INCENTIVES: Service-contingent Loans and Scholarships

NARRATIVE DESCRIPTION:

In return for an agreement to practice in West Virginia upon completion of their residencies, the Medical Association through 1985 gave scholarships to state residents attending West Virginia and Marshall Schools of Medicine. The program has not given out any scholarships since 1985, although there are still students in medical school who are receiving scholarship payments until they graduate. Interest on these scholarships will be forgiven for one year of practice anywhere in the state for each year of aid. Sometime in 1986, a loan program will be implemented in each of the two West Virginia medical schools. Its structure has not yet been determined.

GOALS: 1. Retain state medical graduates within the state.

PARTICIPATING INSTITUTIONS: West Virginia University School of Medicine, Marshall University School of Medicine.

ELIGIBILITY: State resident, financial need, attending WVU or MU in West Virginia.

AREA SELECTION CRITERIA: Anywhere in state.

West Virginia

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$ 1,500	\$1,500	\$ _____	\$6,000	4
<u>SERVICE OBLIGATION</u> One year of service in state per year of aid for forgiveness of interest on loans.			<u>BUYOUT PROVISIONS</u> Principal and interest at prevailing rate.	

STANDARDS FOR
PROGRAM EVALUATION:

OUTCOME:

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$21,600	\$21,600	\$24,000

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	0%
LOCAL:	0%
PRIVATE:	100%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	16	16	16
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

West Virginia

PROGRAM (Date Initiated): West Virginia AHEC (1972)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: John R. Pearson, M.D., AHEC Program Director
Address: West Virginia University
Department of Community Medicine
900 Chestnut Ridge Road
Morgantown, WV 26505
Telephone: 304-293-2502

TYPE OF INCENTIVE: AID IN PRACTICE: AHECs

NARRATIVE DESCRIPTION:

The West Virginia AHEC was originally established with federal funds to improve health care in Charleston, which was suffering from poor physician distribution and training and inadequate facilities. Since then, the situation in Charleston has improved.

The program now focuses primarily on public education on health issues. A statewide health education consortium has been formed, composed of all public and private health educators in the state. The consortium's objective is to address individual health problems on a multi-tiered level. The AHEC also runs continuing medical education programs at 26 sites throughout the state.

The AHEC operates on the assumption that involvement of local community members in the design and implementation of all programs is vital to the programs' success. Therefore, the staff in the Morgantown AHEC office interface continuously with state and local health officials, mayors, and local organizations like the Kiwanis Club, to put on health-related programs. This level of community involvement extends to funding some of the programs outside of the AHEC's limited budget.

GOALS:

1. Attract physicians to rural areas.
2. Improve access in rural areas.
3. Retain state medical graduates within the state.

PARTICIPATING INSTITUTIONS: All health professionals and institutions

CLINICAL SPECIALTIES:

AREA SELECTION CRITERIA: HMSA

STANDARDS FOR
PROGRAM EVALUATION: Physician manpower

West Virginia

OUTCOME: West Virginia has improved its distribution of physicians since the inception of the AHEC program.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$100,000*	\$100,000*	\$100,000*

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	100%*
STATE:	0%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

* Reflects federal funds only; in-kind local contributions not included.

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	_____	_____	_____
% In-State Residents	_____	_____	_____
% Training/ Practicing in Rural Setting	_____	_____	_____
% Rural Origin	_____	_____	_____
% Male/Female	_____	_____	_____
% Minority	_____	_____	_____

WISCONSIN
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
-				-			X			

X = Presence of program.
+ = Program added since 1981.
- = Program discontinued since 1981.

Wisconsin

PROGRAM (Date Initiated): Wisconsin Office of Rural Health (1975)

ADMINISTRATIVE LOCUS: University of Wisconsin-Madison

ADMINISTRATOR:

Director/Contact Person: Fred Moskol, Director
Address: Office of Rural Health
810 University Bay Drive
Madison, WI 53705
Telephone: 608-263-6690

TYPE OF INCENTIVE: AID IN PRACTICE: Placement

NARRATIVE DESCRIPTION:

New Physicians for Wisconsin (NP4W) has a mission to accept any community of the state which seeks a physician. The program works as a paper search. Advertising for physicians, developing profiles of communities, assisting with clinic designs, financial arrangements, and site visits are all available through this program.

New Physicians Select Plan (NPSP) is a more forward program which assists specific communities in their recruitment efforts. A field representative develops a program for the community and essentially staffs the local effort.

Both of these programs are run through the University of Wisconsin, Office of Rural Health, Department of Professional and Community Development.

GOALS:

1. Match physicians with communities in need.
2. Balance physician supply and demand.

PARTICIPATING INSTITUTIONS: Communities and physicians.

CLINICAL SPECIALTIES: All primary care.

AREA SELECTION CRITERIA:

STANDARDS FOR

PROGRAM EVALUATION: Retention of physicians placed.

OUTCOME: 83% of family practice physicians placed have remained in the state; 23% of internists have remained.

ANNUAL FUNDING
LEVELS:

	FY 1983	FY 1984	FY 1985
	\$ _____	\$ _____	\$ _____

Wisconsin

CURRENT SOURCE	FEDERAL:	0%
OF FUNDING:	STATE:	0%
(PERCENT)	LOCAL:	0%
	PRIVATE:	0%
	TOTAL:	0%

NOT RELEVANT TO THIS PROGRAM

PARTICIPANT PROFILE:	1983	1984	1985
Total #			
% In-State Residents			
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

WYOMING
STATE HEALTH PROFESSIONS DISTRIBUTION PROGRAMS

EXPERIENCES DURING EDUCATION				FINANCIAL INCENTIVES			AID IN PRACTICE			
TARGETED PRIMARY CARE RESIDENCIES	SEAT PURCHASE	PRECEPTORSHIPS	OTHER CURRICULUM CHANGES	SERVICE-CONTINGENT LOANS AND SCHOLARSHIPS	OTHER LOANS	OTHER SCHOLARSHIPS	PLACEMENT	GUARANTEED INCOME	LOANS	AHECs
				X						

X = Presence of program.
 + = Program added since 1981.
 - = Program discontinued since 1981.

Wyoming

PROGRAM (Date Initiated): Wyoming Medical School Contract Program (1975)

ADMINISTRATIVE LOCUS: State

ADMINISTRATOR:

Director/Contact Person: John Corbett, M.D., Associate Dean for
Rural and Community Health
Address: University of Wyoming
College of Human Medicine
Laramie, WY 82071
Telephone: 307-266-3076

TYPE OF INCENTIVE: **FINANCIAL INCENTIVES: Service-contingent Loans and Scholarships**

NARRATIVE DESCRIPTION:

To increase the physician-to-population ratio in the state, the Wyoming legislature authorizes funds to insure admission of qualified state residents to the University of Utah School of Medicine and Creighton University Medical School, currently reserving 10 spaces at Utah and 20 spaces at Creighton. Students apply directly to the medical schools for admission. Once accepted, Wyoming pays a rate per student (\$29,300 at Utah; \$30,000 at Creighton) directly to the medical schools. Upon completion of medical school, the student is responsible for repaying Wyoming for the cost of education in one of three ways: 1) practicing in Wyoming for three years upon completion of training; 2) taking a family practice residency in Wyoming; or 3) repaying the principal interest-free within a period of eight years.

GOALS:

1. Increase the number of physicians in Wyoming.
2. Ensure access to medical school for qualified state residents.

PARTICIPATING INSTITUTIONS: Medical schools.

ELIGIBILITY: State resident, acceptance to University of Utah School of Medicine or Creighton Medical School.

AREA SELECTION CRITERIA: Anywhere in the state.

Wyoming

CONDITIONS:

<u>MINIMUM ANNUAL AWARD</u>	<u>MAXIMUM ANNUAL AWARD</u>	<u>AVERAGE AWARD</u>	<u>OVERALL MAXIMUM AWARD</u>	<u>MAXIMUM YEARS OF AID</u>
\$	\$	\$29,300 at Utah; \$30,000 at Creighton	\$	4

SERVICE OBLIGATION

Practice for 3 years in Wyoming, or take family practice residency in Wyoming.

BUYOUT PROVISIONS

Repayment of principal, interest free, within 8 years.

STANDARDS FOR

PROGRAM EVALUATION: Number of participants fulfilling service obligations.

OUTCOME: Of participants since 1975, 75% have fulfilled their service obligations; 25% have bought out.

ANNUAL FUNDING
LEVELS:

<u>FY 1983</u>	<u>FY 1984</u>	<u>FY 1985</u>
\$2,290,371	\$2,448,062	\$2,773,862

CURRENT SOURCE
OF FUNDING:
(PERCENT)

FEDERAL:	0%
STATE:	100%
LOCAL:	0%
PRIVATE:	0%
TOTAL:	100%

PARTICIPANT
PROFILE:

	<u>1983</u>	<u>1984</u>	<u>1985</u>
Total #	120	120	120
% In-State Residents	100	100	100
% Training/ Practicing in Rural Setting			
% Rural Origin			
% Male/Female			
% Minority			

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